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FINAL REPORT

A REVIEW OF
QUALITY OF WORKLIFE ISSUES
OF NURSES
IN NEW BRUNSWICK

Job No. 1165 **July 15, 1988**

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EXECUTIVE SUMMARY

Approach and Structure

This study was commissioned by the New Brunswick Nursing Resources Advisory Committee in an effort to investigate quality of worklife issues that are of concern to New Brunswick nurses. The primary objective of the study was to identify potential solutions to concerns identified in research.

In an effort to produce a comprehensive examination of the present situation among nurses and to identify realistic solutions, research for this project has been conducted in six phases.

The first phase of the study consisted of a review of current (most recent 5 years) North American literature.

Phase two of research included interviews with key informants representing other governments; health care delivery agencies; academia; and nursing practice.

The Administration of a questionnaire, designed to examine quality of nurses' worklife, constituted phase three.

The fourth study phase involved the convening of focus groups throughout the province, each of which contained representatives from hospitals, nursing homes and community nursing.

Phase five consisted of interviews or meetings with nursing managers, nursing professors, health care delivery managers, nursing organizations and health service planners or program consultants.

Each of the described research phases is presented in a separate section of the report. Alone, each section can be viewed as a report into itself, however combined they present a comprehensive examination of quality of worklife among New Brunswick's nurses and provide recommendations of practical, feasible and attainable solutions to the identified concerns.

Literature Review

As indicated by the reviewed literature, the problem of nurses' job dissatisfaction is real and is becoming ever more increasing. Although not all places experience this dissatisfaction to the same degree, it is evident that even marginal satisfaction can quickly turn to dissatisfaction, and result in staff turnover, absenteeism and poor quality of care provision if corrective measures are not employed prior to further deterioration.

Key Informants

Information obtained from these sources include a complete understanding of the clinical ladder concept; and the experiences of other jurisdictions in attempting to understand and cope with nursing shortages and difficult working conditions.

Similar research activity was being undertaken by Metro Toronto and Quebec's Anglophone hospitals concurrently with this study. Questionnaires were developed based on the same variables identified for research in this study. In both cases, data gathering is complete and analysis is underway.

Reports are anticipated by late summer. These studies were initiated out of concern for serious shortage and turnover problems, and their proponents recognition that there could be a number of contributing factors.

It is worth noting that, in contrast to the situation in New Brunswick, these solution-seeking efforts were only undertaken following the onset of serious nursing shortages. Problem symptoms tend to appear in progressive stages beginning with expressions of concern and disillusionment with the quality of care provided, moving on to increased absenteeism and finally high turnover rates (Sheridan, 1985).

Questionnaire

The overall analysis indicated that New Brunswick nurses are generally more satisfied than dissatisfied with their working conditions. As is explained in the Tables presented, however, there are specific areas: pay, promotional opportunity, kinship, scheduling, educational opportunity and decision-making, which are bordering on relative levels of dissatisfaction. It is assessed that these factors need be addressed to avoid further deterioration.

Focus Groups

The majority of focus group participants indicated a high level of dissatisfaction with the current situation among nurses in New Brunswick. It was generally explained that although they "liked" nursing they would not have considered it as a profession if they had known "what they now know". Most participants agreed that they would hesitate to recommend this field to a young person asking their advice. It was felt that unless the present situation was drastically changed there would be few people interested in entering the profession and the difficulty in maintaining those presently employed in the field would increase. As indicated by one group of participants, "as it stands now, the reality of nurses worklife is such that it will not attract quality candidates or secure those already in nursing".

Interviews

The information obtained from individual interviews indicated that the majority of participants felt that generally, nurses in New Brunswick are dissatisfied with their quality of worklife. This finding was consistent throughout each of the interviewed factions, and disagreement was seen primarily among those who were not directly involved with nurses at a working level. Nurses employed in Nursing Homes and/or Community Nursing were perceived as experiencing less job dissatisfaction than those employed in hospitals, however no one group was identified as immune to the factors which contribute to job dissatisfaction.

A variety of factors were identified by those interviewed, as contributing to job dissatisfaction among nurses however, workload, recognition and scheduling were viewed as the major factors effecting quality of work assessment.

It is particularly important to report on the observations by nursing managers concerning their own problems and needs. As a group, they are concerned about inadequate opportunities to participate in overall facility/agency management activities, either as members of executive management or through direct involvement with boards of directors. In addition, they recognize their needs for formal management training.

The majority of interviewees indicated a great need for changes that would result in quality of worklife improvement for nurses. However, they have not clearly demonstrated their commitment to lead in the implementation of worklife improvements. Of particular concern is the indication that nurse managers appear no more committed to fostering change than those less directly involved.

In addition to interviews with individual nurses and administrators, meetings were held with representatives of eight organizations with a high level of interest in nursing concerns, including:

- The President and Executive Director of the New Brunswick Nurses Union
- The President and Executive Director of the Nurses Association of New Brunswick
- The President of the Management Nurses Association
- The President, members of the Board and the Executive Director of the Association of New Brunswick Registered Nursing Assistants
- The senior staff of the New Brunswick Hospital Association
- Members of the faculties of one diploma and one University School of Nursing
- The Board of Management's negotiator for the nurses collective agreements
- Nursing consultants and other head office staff with professional nursing qualifications in the Department of Health and Community Services.

The input from the New Brunswick Nurses Union and the Nurses Association of New Brunswick were obtained in written documents and in discussions based on their content. They are appended to this report (see Appendices F and G). It is encouraging that the problem descriptions and recommendations for change from these groups are notably similar. In addition, this material was generally consistent with the findings of other components of the research undertaken in this study. The level of concern and willingness to participate in positive changes in the workplace are high among both organizations representing nurses in New Brunswick.

Conclusions

While the level of nursing job satisfaction in New Brunswick is still generally high, and drastic corrective measures are not required, it would be inappropriate to conclude that the nursing work place is not in need of improvement. It is fortunate that the many difficulties that nurses experience have not, to date, resulted in significant job dissatisfaction. It would be unwise, however, to assume that this situation will persist.

Stated in different terms, the nursing worklife environment in New Brunswick is not bad, but neither is it as good as it could or should be.

Quantitatively, as measured in the mail survey segment of our research, the problems are not great. However, our qualitative impressions from the focus groups and interviews suggest that job satisfaction will deteriorate without the creation of more positive work environments.

As job dissatisfaction is a major reason that nurses resign, turnover can be reduced by adjusting the working conditions that contribute to this dissatisfaction (Weisman, 1982).

Consequently a preventive approach is proposed, that will not only reverse deterioration in the quality of nursing worklife, but result in measureable and expressed improvements.

Taken together our findings indicate that three areas cause the most aggravation for nurses at all levels. These are decision-making, compensation and scheduling. While some of the recommendations made in this report touch on other areas, attention to these major factors is likely to have the greatest impact on nurses' job satisfaction.

It is important to note that there are numerous examples in the province of practises that enhance the worklife of nurses. The concern is that there are too many situations in which rigid approaches exist, particularly in the areas of decision-making, scheduling, and the facilitation of continuing education.

There is not a shortage of nurses in New Brunswick. Rather there is a shortage of nurses willing to work under the conditions that prevail in some settings. Maintaining the rigid approaches to recruitment and scheduling, in an attempt to obtain the maximum involvement of existing staff will contribute to more practising nurses opting out of practise or choosing different work places and will discourage inactive nurses from reentering practise.

It is becoming increasingly important, as well, to recognize that New Brunswick's nursing workforce is viewed as potential employees by health care services throughout North America. Incentives to relocate can be extremely attractive. While this is likely to primarily affect new graduates, the provincial health care system cannot afford to overlook the need to remain competitive. These new graduates will be needed to fill positions in New Brunswick.

Attitudes, knowledge and flexibility are the key attributes that will determine the extent to which the system is prepared to change and the rate at which change will occur.

Attitudes relate to the way in which nursing roles are perceived both within the profession itself and among others who employ, interact with or represent nurses.

Flexibility refers to the extent to which nurses themselves, the organizations that represent them, and their employers are prepared to recognize and act on the reality that many nurses throughout their careers must seek a balance between their family, practise and educational responsibilities.

Knowledge is important as a foundation for identifying what needs to be changed, the approaches that could have a positive impact and the methods to implement these approaches.

At the most strategic level, the provincial government, it is noteworthy that the Minister of Health and Community Services has recognized the importance of nursing resources by establishing the Nursing Resources Advisory Committee. The Minister's decision, in response to a recommendation from the Nursing Resources Advisory Committee, to undertake this study is further evidence that here is a willingness to address the need for nursing worklife improvements.

The interest shown by all individuals and organizations who participated in the project indicates that there is considerable willingness to change and an existing base of knowledge about many of the improvements that would enhance nursing worklife. A significant finding is the extent of consensus among the major organizations (New Brunswick Hospital Association, Nurses

Association of New Brunswick and New Brunswick Nurses Union) regarding the importance of "professionalizing" nursing practise and nursing administration. The briefs from the Union (New Brunswick Nurses Union) and the Association (Nurses Association of New Brunswick) appended to this report can be characterized by the extent of common ground that unites the organizations that represent nurses, rather than any major differences that place them in conflict.

The New Brunswick Hospital Association can have a significant effect on the attitudes and knowledge of Board members and administrative staff and, according to their staff, are prepared to play an active role in assisting hospitals with the change process.

Recommendations

Recommendation # 1 - Decision-Making

It is recommended:

That decentralized, participative management approaches be encouraged to increase the involvement of nurses at all levels in decision-making affecting their practise.

Recommendation #2 - Workload and Roles

It is recommended:

That safe nursing be established based on an agreed upon nursing conceptual model and on current nursing workload measurement.

Recommendation # 3 - Recognition

It is recommended:

That there be recognition of knowledge and skills acquired by nurses through the application of the clinical ladder concept within the health care system.

Recommendation # 4 - Compensation

It is recommended:

That employers of nurses provide financial compensation consistent with levels of responsibility and variations in nursing working conditions.

Recommendation # 5 - Education

It is recommended:

That access to Continuing Education Programs be promoted through the provision of replacement budgets, the cooperative development of post-basic certificate programs and management courses as well as providing for an adequate orientation program and access to exchange programs.

Recommendation # 6 - Family Responsibilities

It is recommended:

That kinship responsibilities be recognized by employing agencies by offering less traditional schedule options and a variety of leave of absence options (extended maternity leave, sabbatical leave, and deferred incomes).

Recommendation # 7 - Scheduling

In order to allow for more flexibility and creativity in scheduling, it is recommended:

1) That employers work collaboratively with staff nurses and their union representatives to develop and design creative staffing formulae which would meet standards of quality patient care while limiting rotation and that these be piloted to test their effectiveness. This, we believe would have a positive effect on staff-retention and recruitment and lower the incidence of unplanned leave.

2) That the responsibility for staffing/scheduling be that of the unit manager/head nurse. This strategy allows for more commitment of staff nurses and less rigidity in its implementation.

3) That utilization of part-time and casual employees be improved. Casual employees should be pre-assigned to a limited number of units and unit managers, receive an appropriate orientation based on needs and be involved in continuing education programs. Improved utilization of part-time employees should be studied so continuity and quality of care is not affected by its increased utilization.

4) That compensation be given for unused sick leave at the end of the year to lower the incidence of unplanned sick leave utilization.

Recommendation # 8 - Implementation

It is recommended:

That immediate steps be taken to demonstrate to nurses that the potential worklife problems that they experience are recognized and are being addressed.

1. APPROACH AND STRUCTURE

This study was commissioned by the New Brunswick Nursing Resources Advisory Committee in an effort to investigate quality of worklife issues that are of concern to New Brunswick nurses. The primary objective of the study was to identify potential solutions to concerns identified in research.

In an effort to produce a comprehensive examination of the present situation among nurses and to identify realistic solutions, research for this project has been conducted in six phases.

The first phase of the study consisted of a review of current (most recent 5 years) North American literature. This process provided an identification of concerns nurses have regarding quality of worklife and examined possible solutions to these concerns. In addition, the literature review provided information useful in the development of reliable research instruments.

Phase two of research included interviews with key informants outside the province representing nursing associations; health care delivery agencies; academia; and nursing management. The information obtained from these interviews was used to supplement the literature review, as not all useful material has been published.

The administration of a questionnaire, designed to examine quality of nurses' worklife, constituted phase three. This instrument was designed to provide quantitative data from a representative sample of New Brunswick nurses, and to allow for statistical analysis of the functioning correlates surrounding job satisfaction.

1. (Cont'd)

The fourth study phase involved the convening of focus groups throughout the province, each of which contained representatives from hospitals, nursing homes and community nursing. This technique was utilized as a means of directly accessing the target population to obtain information defining the nature and extent of the 'problem' and to identify and consider solutions specific to the situation in New Brunswick.

Phase five consisted of interviews or meetings with nursing managers, nursing professors, health care delivery managers, nursing organizations and health service planners or program consultants. The purpose of this endeavor was to obtain a more complete assessment of the current situation in nursing and to discuss the feasibility of potential solutions or improvements.

The final phase of the study involved the integration and comparison of all results, obtained from the previously described phases, and the formulation of conclusions and recommendations based on these findings.

Each of the described research phases is presented in a separate section of the report. Alone, each section can be viewed as a report into itself, however combined they present a comprehensive examination of quality of worklife among New Brunswick's nurses and provide recommendations of practical, feasible and attainable solutions to the identified concerns.

2. LITERATURE REVIEW

2.1 Introduction

Quality of worklife refers to the relative level of goodness or excellence derived from a specific occupational environment (Chaplin, 1985). This construct is often equated with job satisfaction (Fuszard, 1984), however, there appears to be some controversy in the literature regarding this verification of terms. It is unclear as to whether job satisfaction is synonomous with worklife quality or occurs simply as a positive correlate. Research supporting either stance proves valid, yet due to the similarities in variable measurement, this report regards them as one.

Quality of worklife, and its correlates, have been examined among various occupational groups, and the results from such investigations have identified individuals in the helping professions (i.e., nurses, counsellors, social workers, and the like) as primary targets for the potential consequences of inadequate working conditions. As indicated by Edelwich and Borodsky (1980), job dissatisfaction and its symptoms are not limited to those employed in the human services, however, incidence of this phenomenon do not occur with anything like the same regularity or carry with it the same social costs in other occupations as it does in the human services, where it takes on special characteristics and a special intensity. Findings such as these have produced further study among the various human service careers and nursing has been a major occupation of interest. (See Blegen et al., 1987; Dolan, 1987; Larson et al., 1984; Sanger et al., 1985.)

2.1 (Cont'd)

The quality of worklife in professional nursing has, in recent years, drawn increasing concern from numerous sectors of society, including the nursing profession; hospitals and other health care organizations; the Department of Health and Community Services; and the government.

While each of these factions have diversified interests, they are united in the pursuit of quality patient care, which is significantly related to nursing worklife quality.

This review focuses on the identification of the concerns nurses have regarding working environments and identifies possible solutions to these concerns. Emphasis has been placed on current (within the last five years) Canadian literature, however, American research has also been utilized in an effort to substantiate findings from Canadian sources and to provide a comprehensive examination of potential solutions.

The review has been organized under the following sections:

Problem Description - examining the current concerns of professional nurses and identifying personal characteristics which tend to increase susceptibility to worklife problems.

Nature and Content of Job Dissatisfaction - identified factors affecting job satisfaction, indicators of dissatisfaction and current primary areas of concern.

Potential Solutions - examines researched methods of combating job dissatisfaction among nurses in various settings.

2.1 (Cont'd)

Summary and Discussion - the information in the review is summarized. Implications of discussed findings, in terms of program implementation, are emphasized.

2.2 Problem Description

2.2.1 Identification of Current Situation

Frustration, dissatisfaction and subsequent resignation, either temporary or permanent, are terms which describe the overall experience of professional nurses working in the health care system today (AHQ, 1988; Alberta Association of R.N., 1988; Attridge et al., 1987). This experience is not revolutionary nor is it limited to this specific field, however it is substantiated as the number of individuals indicating their concern increases, and as a potential shortage of human resources becomes evident.

As indicated in a study conducted by the Committee on Registered Nurse Availability (1981), the problem is not that nurses are unwilling to provide quality patient care, but rather that they are frustrated because they are unable to do so.

> "Workloads that create care-by-crises, non-nursing functions and lack of input into decision-making and effecting change ..." (Committee on Registered Nurse Availability, 1981).

2.2.1 (Cont'd)

... are viewed as creating dissention and attrition and thus reducing or interfering with effective treatment of care recipients.

Nurses in all areas of the health care delivery system are identified as being burdened with ever increasing demands, much of which is not related to providing care; inflexibility of senior staff; and unsympathetic supervisory and middle staff, who reflect the validity of employee concerns (Ogilvie and Associates, 1981). Efforts have been made in the past to address such problems, however, the inadequacy of such attempts surpassed their potential strengths and produced minimal success. These past failures to rectify problem situations serve only to facilitate discouragement among practicing nurses, and to deepen the ever increasing discontent within this milieu.

As a result of the present situation within the nursing profession, a concern has arisen regarding increased job termination and its effects not only upon patient care but also on institutional operation (AHQ, 1988; Comite-Airseur ADHOC aux Directeurs des Hôpitaux Bilingnes and Francophones du N.B., 1988; R.N.A.B.C., 1987). To date, there is an adequate number of practicing nurses in New Brunswick to meet the operational needs, however, this case appears to be changing, and may continue to do so if proper corrective measures are not employed.

2.2.1 (Cont'd)

According to 1987 statistics, there were a total of 6,894 nurses registered in the Province of New Brunswick, yet for reasons not presently identified, 737 of these individuals chose not to practise.

As indicated by the survey conducted in 1981 on Registered Nurse Availability in New Brunswick, "... nurses are unwilling to work in the circumstances prevalent in many settings, particularly the hospital." (Committee on Registered Nurses Available)

Inadequate working conditions appear to be prime deterents, which lead nurses to either withdraw from practise entirely or opt for work in health care settings which exclude hospitals. This reality has created a great deal of concern, as it results in both a financial drain on the institution and a shortage of staff to provide care.

2.2.2 Work Environment

The environment and/or working conditions, are identified as problematic by professional nurses, however it is necessary to recognize that no relationship or job situation meets the needs of every individual (Larson and Brown, 1984). It is often past experience, life position and personal characteristics that contribute to the intensity of problem impact. Each individual perceives the work differently and hence may deem a situation problematic that others feel is challenging (Lazarus, et al., 1952).

2.2.2 (Cont'd)

As a result of this reality, it is difficult to identify a specific group of characteristics that tend to be attributed to nurses experiencing worklife dissatisfaction, however, certain trends have been observed.

One such observation identified age as a primary correlate to job dissatisfaction. In a study conducted by Blegen and Mueller (1987) wherein data was collected from 370 full-time registered nurses, age was determined to have a significant effect on perceived quality of worklife as indicated in the data analysis age was positively correlated with job satisfaction, therefore it was concluded that older nurses tend to be more satisfied with their jobs than their younger counterparts.

Family responsibilities and/or kinship are factors that have also been identified as relevant in examining worklife quality among nurses. A study carried out by Gaertner (1984) utilized the role conflict-job satisfaction model in an attempt to explore the relationships between family/life-cycle variables, attraction to work and employment status of nurses. In this study, data was obtained from 4,191 full and part-time nurses, using a Likert Scaling method, with each question being rated on a 5-point scale. Topics including level of direct patient care, professional status opportunities, salary, scheduling and availability of child care were represented in the survey. The results of this study revealed that the factor which generates universal dissatisfaction among this sample of

2.2.2 (Cont'd)

nurses is that of the availability of child care. The strength of this finding was attributed to the difficulty these individuals experience when attempting to obtain child care which corresponds to the shifts they work. It was also identified that marital status and the presence of children in the home are related to job satisfaction, however, the presence of young children has a greater effect than does marital status. These findings indicate a high level of dissatisfaction among married nurses with children and explain this phenomenon as related to the demands placed upon them by their jobs.

The three demographic variables, of age marital status and parenthood, are by no means the only factors related to job satisfaction. Elements such as language, position, education, hospital size and pay have also been attributed to quality of worklife assessment (Blegen et al, 1987; Sanger et al., 1985). The element of language used in employment setting as related to job satisfaction has been eluded to in some of the literature, however, no specific findings have been identified. The other above mentioned factors are thoroughly examined in the following section.

2.2.3 Nature and Context of Job Dissatisfaction

2.2.3.1 Factors Affecting Job Satisfaction

Nurses' job satisfaction has been studied extensively. A review of this literature by Hinshaw and Atwood (1984) identified numerous factors, including demographic

2.2.3.1 (Cont'd)

traits, health care environments and actual job characteristics, which influenced job satisfaction. Their investigation concluded that the majority of influencing factors had been studied individually rather than collectively, had been explored in relation to limited settings and provided little background material supporting or disproving their findings, thus the impact of these variables functioning simultaneously was as yet unknown (Hinshaw and Atwood, 1984).

One of the pioneer attempts to address the question raised by Hinshaw and Atwood (1984) was made by Sanger, Richardson and Larson (1985). In this examination of job satisfaction, a total of eight factors, including: workload, accomplishment, relationship with head nurse, relationship with physicians, relationship with nursing administrator, decision-making and utilization of knowledge and skills were measured using a questionnaire developed by Peterson and Schauwecher (1975-76). The analysis reported that each of the eight identified variables had a significant effect on assessed job satisfaction among participants. In conclusion, it was noted that identifying specific job satisfiers is an important initial step, however, the collected information serves only as a basis for which to plan, intervene and evaluate (Sanger et al, 1985, p. 46).

2.2.3.1 (Cont'd)

As support grew regarding this multiple factor analysis of job satisfaction, research on the topic became more comprehensive and directed. A study conducted by Blegen and Mueller (1987) sought to further examine this construct. Using a model of satisfaction, developed by Price and Mueller (1986), these social scientists identified thirteen primary explanatory variables, involved in the measurement of job satisfaction. These included:

- Opportunity for alternative jobs outside of the employing hospital;
- Routinized work;
- Autonomy in job related decisions;
- Job related communications;
- Social integration with other nurses in the work unit;
- Pay fairness;
- Fringe benefits;
- Opportunity for promotion;
- Workload
- Motivation to produce high levels of job performance;
- Level of general training
- Level of kinship responsibility; and
- Unit size.

In addition to these thirteen identified primary variables, five other correlates; age, length of service in hospital, full/part time employment, shift assignment

2.2.3.1 (Cont'd)

and position in hospital were examined in the final analysis (Blegen and Mueller, 1987, p. 228).

The results of this investigation indicated that nurses, in general, were more satisfied than dissatisfied and that each of the identified variables reached statistically significant levels in regard to job satisfaction. In summary, nurses who were most satisfied tended to be those assigned to non-routine jobs; who had opportunities for promotion, who were older, experienced fairly distributed rewards, who worked day shift and who were not over or under worked (Blegen and Mueller, 1987, p. 236).

These two studies, that of Sanger et al, (1985) and Blegen and Mueller (1987) provide the most comprehensive examination of factors influencing job satisfaction among nurses of all the literature examined. Each of these sources indicates clearly that the level of job satisfaction and conversly job dissatisfaction is dependent on the number and intensity of these constructs functioning at a given time, however not all elements are equally influential.

2.2.3.2 Consequences of Job Dissatisfaction

The increased interest in the study of job satisfaction/quality of worklife among nurses may be largely due to the consequences of high levels of job dissatisfaction and the effect on the health care system. The results of such investigations have been primarily directed toward three goals:

1) To reduce staff turnover;
2) To reduce absenteeism; and
3) To improve the quality of patient care provided (Larson, Lee, Brown, and Shorr, 1984).

2.2.3.3 Potential Solutions

As a result of extensive research and investigation regarding the problem of job dissatisfaction among professional nurses a number of potential solutions have been designed and implemented in various settings. Each of the following approaches have been developed in an effort to: reduce staff turnover, and absenteeism, and to improve the quality of patient care provided.

2.2.3.3 (Cont'd)

These innovative staffing measures, designed to improve nurses quality of worklife, include:

i) Twinning (Job Sharing)

This approach consists of two permanent part-time positions matched to fill an unfilled full-time position. Two individuals share the responsibility of the position while working permanently part-time, with known rotations and benefits (as opposed to causal employment).

Where a twinned position is filled, the nurses agree between themselves how they will cover work, how they will cover the position, allowing for a minimum of two shifts per week. In other words, if one of the 'twins' wanted to work all afternoons, and the other all mornings this would be acceptable. Vacations are to be covered by the partners on a full-time bases. If one twin is ill, she calls her partner first to see if she can fill in for her. If this cannot be arranged, the hospital takes over the staffing of the position. (Ref. Dianne Doyle, Director of Patient Services; Mount St. Joseph Hospital - Vancouver, Jean Stuart, Director of Nursing Services, University of B.C. Health Sciences Centre Hospital.)

2.3.3.4 The Baylor Plan

The Baylor Plan is a plan where nurses contract with their employer to work in one of the following modes:

a) Monday through Friday only during the day; these nurses work 7.5 hrs/day or 37.5 hrs/week (75 hours every 2 weeks) for full pay and benefits.

or

b) Monday through Friday only to cover evenings and nights; three 12 hour shifts one week and two 12 hour shifts the other for a total of 60 hours every two weeks. They too receive full pay and benefits.

or

c) Two 12 hour shifts during the weekend only (48 hours every 2 weeks) with full pay and benefits.

The nurses contract with their employer for one of these shifts and keep it for a certain period of time (i.e. 1 to 2 years). At the end of the contract, he/she can either renew the old contract or establish another, depending on the availability of shifts.

2.3.3.4 (Cont'd)

Levels of Practise (Clinical Ladder) Program:

This program offers the nurse an opportunity for promotion through an established career ladder which takes into account the educational background of the nurse as well as his/her relevant experience (D. Barkyte, 1987).

Concept of Primary Nursing

Primary nursing is a concept which places the accountability for practise in the hands of the nurse and where the decision making is decentralized.

Four (4) basic principles for accountability are identified for this model of nursing practise:

1) 24-hour responsibility and decision making for several patients by one nurse (she decides how care will be given to her group of patients, 24-hours a day, seven days a week).

2) Case method of assignment. Daily assignments for patient care are based on the care needs of the patients and the ability (nursing skills) of the staff available - not on the basis of room assignment.

2.3.3.4 (Cont'd)

3) Direct communication between caregivers. There is a direct flow of communication between the nurse on one shift and the nurse on the next shift and between the nurse and other care-givers.

4) Role of the head nurse. The head nurse has a crucial role as a leader, communication facilitator, clinician and resource-person for the staff nurse as they plan, implement and evaluate the care of their patients. She is the quality control agent for the unit (Gilles, 1982, pp. 232-246).

In some institutions (Sunnybrook Medical Centre, Toronto: Donna Crinklaw Wiancko) the nursing department encourages nursing staff on each unit to select a committee which represents all levels of nursing personnel. This elected body, known as the primary nursing committee, decides how primary nursing will be implemented and practised on its unit. The unit clinical nurse specialist becomes a resource and facilitator for the committee as well as for the unit staff.

2.3.3.4 (Cont'd)

Communication Upward, Downward and Lateral:

In this process, nurse managers meet to identify issues of importance to nursing staff and develop a written message about that issue for distribution. Each manager then conducts a group meeting with his/her subordinate supervisors. During these meetings the message is discussed thoroughly and the supervisors "role play" the discussions they will have with their staff when they distribute the information. Each supervisor is then expected to communicate the message either in group meetings or through informal conversation to all staff. Finally, short debriefing meetings are conducted by the managers with their supervisory groups to gauge employee reaction and identify new issues for discussion. These issues are taken to top management group meetings where the next message is prepared and discussed. (Baird, 1987)

Employee/Management Advisory Committees:

Employee/management advisory committees consisting of nursing staff representatives and supervisors selected for participation by nursing administration, can be useful vehicles for communicating employee concerns to management, carrying messages

2.3.3.4 (Cont'd)

from management to staff, giving advice concerning needed or proposed changes such as means to reduce costs, or reviewing messages that administration is considering sending to staff. (Baird, 1987)

Hospital Publications or Letters to Employees:

Through a hospital publication sent to employees, administration communicates to staff reasons behind administrative decisions as well as the plan of action it is considering. The administration demonstrates that they know at least in general terms, the conditions on the floor and that they are basing their decisions on the day to day reality of the units. Employee opinion surveys are conducted from time to time by the administration to obtain evidence of the employee's concerns prior to providing action or follow-through. (Baird, 1987)

2.4 Supportive Work Environment Measures

There are a number of measures which have been implemented which are designed to improve the work environment of nurses:

2.4.1 Nurse to Nurse Consultation:

The program is run by a full time consultant with the help of registered nurses from a phychiatric unit. The services provided include consultation to nursing staff and to nursing managers; support groups for experienced staff and new graduates; crisis intervention during times of severe work stress; interpersonal conflict mediation between nurses and physicians and nurses and nursing managers; and stress management education. The nurse consultant holds bi-monthly support group meetings in various units. These groups allow nurses to vent their feelings of frustration with working in acute care bureaucracies; increase introspection and develop problem-solving skills and measures to resolve these frustrations; and to gain peer support for common pressures. The nurse consultant can also be utilized by a unit during high unit stress as well as by the hospital.

2.4.2 Stress Workshop

A series of workshops given by an objective workshop leader can be provided to help nurses express concerns, anxieties, anger and pleasure with certain aspects of their work. As well, participants are provided with material which explains how to recognize job stress. It also teaches how to deal with it creatively through such activities as time management, relaxation techniques, diet and exercises.

2.4.2 (Cont'd)

Relaxation techniques and other stress reducing techniques such as meditation, visualizations and therapeutic touch are taught during these workshops. (Burnaby Hospital, B.C.; Mary Preissl: Nurses Management, 2, Aug. 1987, B.C. Stress Workshop)

2.4.3 New Graduates Program

New graduates could be in orientation throughout the hospital for a six-month period to acquire a better view of the work to be accomplished and be increasingly involved with making important decisions. They could be assigned a tutor on each of the units they work on during this rotation period as well as on the unit where they are to be permanently assigned. Furthermore, they are to be provided with a support group which helps them go through the stress of facing the work reality of the nursing profession for the first time. (Bajmok and G. Gittermau, 1988)

Each of these identified approaches have been implemented and researched (by those referenced) and have proven to increase levels of job satisfaction among practicing nurses.

2.5 Summary and Conclusions

As indicated by the reviewed literature, the problem of nurses' job dissatisfaction is real and is becoming ever more increasing. Although not all places experience this dissatisfaction to the same degree, it is evident that even marginal satisfaction can quickly turn to dissatisfaction,

2.5 (Cont'd)

and result in staff turnover, absenteeism and poor quality of care provision if corrective measures are not employed prior to further deterioration.

Table 1

12 VARIABLES ASSIGNED TO MEASURE QUALITY OF WORKLIFE

	Variable Name	Operational Definition
1.	Accomplishment (n = 5)	The attainment of personally defined goals within the work environment.
2.	Recognition (n = 5)	The acknowledgement of quality care provided and of the efficient execution of duties by administration and co-workers, includes evaluation of performance, reward & reprimand.
3.	Decision-Making (n = 5)	The level of ability to assist in decision-making regarding patient treatment and facility operation.
4.	Utilization of Knowledge & Skills (n = 4)	The ability to exchange ideas, knowledge and skills with colleagues.
5.	Educational Opportunity (n = 5)	The ability to participate in educational programs and to increase expertise with support (via time availability, rescheduling) from the employing facility.
6.	Promotional Advancement (n = 3)	The opportunity for advancement within the work environment.
7.	Pay (n = 2)	The financial rewards received for work conducted.
8.	Workload (n = 7)	Extent to which job demands are either too high or too low.

Variable Name	Operational Definition
9. Scheduling (n = 7)	The preferential selection of shift and work period and the dependence of this flexibility on adequate staffing.
10. Unit Size and Function (n = 5)	The operational scale of the institution; availability of modern equipment; size facilitative to community needs; location accessibility.
11. Job-Related Communication (n = 6)	The interaction between nurses, peers, administration and physicians.
12. Kinship (n = 3)	The willingness of employing facility to accommodate for family and/or personal needs and responsibility.

TOTAL # QUESTIONS = 57

3. KEY INFORMANTS

3.1 Method

3.1.1 Subjects

A total of seven sources were contacted in this research phase. This included:

- The Continuing Education Department, Victoria General Hospital, Halifax
- Metro Toronto Hospital Council study group on Nursing Morale and Retention
- Alberta Association of Registered Nurses
- Registered Nurses Association of Ontario
- Minister's Advisory Committee on Nursing Manpower, Ontario
- Quebec Anglophone Hospitals Task Force on Nursing Manpower
- Several senior nursing managers in major Toronto hospitals

3.1.2 Materials

The materials used in this phase of investigation consisted of a Key Informant's Interview Guide (See Appendix A). This guide was designed to obtain information from agencies which had examined the issue of quality of nurses' worklife and had found ways to improve the situation. The questions, included in the guide, examined the problem which the facility was addressing, the signs of job dissatisfaction they had experienced, the solutions implemented and the results of these endeavours.

3.1.3 Procedure

In this study phase key informants were contacted and interviewed by telephone. Each person was given a description of the nature and purpose of the study and then was presented with the questions from the interview guide.

3.2 Results

Information obtained from these sources include a complete understanding of the clinical ladder concept; and the experiences of other jurisdictions in attempting to understand and cope with nursing shortages and difficult working conditions.

3.2.1 Clinical Ladder

The Victoria General Hospital's experience with this concept is still in the research phase. It is being piloted in nine nursing units, and evaluation results are expected by year end. To date, modes of payment for the various levels have not been determined and nurses continue to be paid on the basis of seniority.

3.2.2 Experiences

Similar research activity was being undertaken by Metro Toronto and Quebec's Anglophone hospitals concurrently with this study. Questionnaires were developed based on the same variables identified for research in this study. In both cases, data gathering is complete and analysis is underway.

3.2.2 (Cont'd)

Reports are anticipated by late summer. These studies were initiated out of concern for serious shortage and turnover problems, and their proponents recognition that there could be a number of contributing factors.

It is worth noting that, in contrast to the situation in New Brunswick, these solution-seeking efforts were only undertaken following the onset of serious nursing shortages. Problem symptoms tend to appear in progressive stages beginning with expressions of concern and disillusionment with the quality of care provided, moving on to increased absenteeism and finally high turnover rates (Sheridan, 1985).

The Alberta Association of Registered Nurses Brief on Concerns of Registered Nurses Employed in Alberta Hospitals and Nursing Homes, presented in March, 1988, covers a broad range of necessary nursing-related changes in the health care system, but it too was in response to a crisis - the January-February, 1988 Alberta nurses' strike.

4. QUESTIONNAIRE

4.1 Method

4.1.1 Subjects

Subjects included 276 practising and non-practising nurses, registered in the Province of New Brunswick, who were contacted via a mailed questionnaire and 104 practising nurses who were presented with the survey questionnaire prior to focus group participation. Respondents receiving the mailed questionnaire were randomly selected from the New Brunswick Nurses' Association registration list. A 10 percent sample was drawn from the 7,047 members registered, for a total of 700. The questionnaires were mailed to 691 potential respondents. Nine were eliminated from the original sample as they were obviously not practising in New Brunswick. Participants comprising the rest of the sample were selectively chosen based on criteria specified in the Focus Group subject section of this report.

4.1.2 Materials

The apparatus used in this research phase consisted of a two-part questionnaire examining factors related to nurses' worklife quality (see Appendix B).

Section I of the questionnaire included twenty-three questions designed to ellicit demographic information from respondents.

4.1.2 (Cont'd)

Section II of the survey consisted of fifty-seven statements, which were sub-divided under twelve specific variable headings, including: accomplishments; recognition; decision-making; utilization of knowledge and skills; educational opportunity; promotional advancement; pay; workload; scheduling; unit size and function; job-related communication and kinship. Each of the statements was scored on a five-point Likert-type scale, with one indicating the statement was never true and 5 assessing it as always true.

Table 1 presents operational definitions of each of the above mentioned variables and identifies the number of statements included in each sub-section.

The format and content of this questionnaire was adapted from instruments used in research conducted by Sanger, Richardson and Larson (1985) and Blegen and Mueller (1987), wherein the previously described factors were identified as significant measures of job satisfaction among nurses.

Quality of worklife and/or job satisfaction are hypothetical constructs which are measurable only through the identification of factors which influence their existence. Therefore in order to obtain a score for level of job satisfaction it is necessary to first obtain scores for each of the separate variables. These individual scores combined produce a meaningful indicator of assessed quality of worklife.

4.2 Procedure

The questionnaires, distributed by mail, were accompanied by an information sheet (see Appendix C) that provided recipients with information regarding the Quality of Nurses worklife study, explained the questionnaire and identified procedures for survey return.

In Section I, of the two-part questionnaire, respondents were presented with questions designed to obtain demographic information. Here, subjects were asked to respond by circling the appropriate number. Participants who were no longer employed in nursing were asked to answer each question with regard to their last job as an R.N., unless otherwise indicated.

Section II of the questionnaire consisted of statements examining specific factors related to job satisfaction. Respondents were asked to circle the number (1 - 5) which best represented the degree to which the statement described their situation.

Respondents were required to return questionnaires by June 2, 1988 in order to be included in analysis.

The procedure followed for questionnaire administration to focus group participants is described in the Focus Group procedure section of this report.

In all cases confidentiality was assured.

4.3 Results

The data obtained from the questionnaires was analyzed in two stages.

4.3.1 Stage One

Data were analyzed with computer assistance using the SAS statistical package. One-way analyses of variance were performed to determine whether age, marital status, age of youngest child, first language, language spoken at work, currently employed as R.N., employing facility, hospital size, education, training or upgrading, area of employment, years worked as R.N., current position, type of nursing used in unit/agency, average daily patient caseload, average caseload of R.N. in agency, rotation, shift, hours worked per week, and salary were predictive of job satisfaction. Scheffe's Test was performed to evaluate whether there were significant differences in mean scores between each of the identified demographic variable sub-groups on assessed level of job satisfaction.

The analysis indicated that the effect of language spoken (English or French) was significant, $\underline{F}(1,374)=6.56$, $\underline{MS}e=0.21$, $p < .05$. The mean scores for the two language groups were 3.26 for English speaking nurses and 3.13 for the French group. The test of significance indicated that individual's who's first language was French were significantly more dissatisfied with their jobs than English speaking participants.

4.3.1 (Cont'd)

Further analysis indicated that the variable of employing facility (hospital, nursing home, or other health care setting) had a significant effect on job satisfaction ratings, $\underline{F}$=(2,368)=13.94, $\underline{MS}e$=0.19, $p < .05$. The mean scores for the three employment groups were 3.13 for those employed by hospitals, 3.37 for those employed by nursing homes and 3.40 for those employed in other health care environments. The test for significant group differences indicated that individuals employed by hospitals were significantly less satisfied than those employed in either nursing homes or other health care environments.

Hospital size (large, medium or small) was also identified as having a significant effect on assessed job satisfaction, $\underline{F}$=(2,294)=4.50, $\underline{MS}e$=0.16, $p < .05$. The mean scores for the three hospital sizes were 3.17 for large hospitals, 3.06 for medium sized hospitals and 3.24 for small hospitals. The test of significance indicated that those employed in medium size hospitals reported significantly less job satisfaction than those employed in small hospitals. No significant difference was observed in relation to large hospitals.

An analysis was conducted in regard to the effect of area of employment on job satisfaction. The results of this analysis indicated that area of employment (general patient care, special intensive care, or administration) had a significant effect on job satisfaction, $\underline{F}$(2,324)=4.22, $\underline{MS}e$-0.19, $p < .05$. The

4.3.1 (Cont'd)

mean scores for the three employment areas were 3.21 for nurses in general patient care, 3.15 for those in special/intensive care and 3.47 for those in administration. A significant difference between groups was identified wherein those employed in administrative positions were more satisfied than nurses in the other two groups.

In regard to current position (general duty staff, head nurse, and other) the analysis indicated a significant effect of this variable on job satisfaction, $\underline{F}(2,363)=6.24$, $\underline{MS}e=0.18$, $p < .05$. Mean scores for the three different positions were 3.17 for general duty staff, 3.27 for head nurses and 3.39 for other positions. Although there was a significant effect of current position no significant differences were observed between the three sub-groups.

The level of assessed job satisfaction was analyzed in relation to participants working rotation (either yes or no). The analysis indicated a significant effect of rotation, $\underline{F}(1,369)=15.19$, $\underline{MS}e=0.18$, $p < .05$. The means for the two groups were 3.13 for those who worked rotation and 3.31 for respondents who did not work rotation. The test of significance indicated that those not working rotation were significantly more satisfied than those working rotation.

In addition to examining the effect of rotation, the effect of shift (day, evening, night) was also explored. The results of this analysis indicated

4.3.1 (Cont'd)

that the effect of shift was significant, $F(2,177)=3.79$, $MSe=0.22$, $p < .05$., however no significant differences were observed between the three groups. The means for each group were 3.33 for those frequently working day shifts, 3.13 for those working evenings and 3.09 for those working nights. As identified by an examination of group means, those working day shifts were more satisfied than individuals in the other two groups, but this difference was not statistically significant.

Duncan's Multiple Range Test demonstrated that neither age, marital status, age of youngest child, language used at employment, present employment as an R.N., education, training or upgrading, total years as an R.N., type of nursing used in employment, average daily patient caseload, average case load of R.N. in agency, hours worked per week, length of employment nor salary were predictive of job satisfaction score ($p > .05$).

4.3.2 Stage Two

Data were analyzed for each of the 12 correlates of job satisfaction (See Table 1) using the SAS statistical package. One way analyses of variance were performed to determine whether the previously described demographic characteristics of subjects were predictive of factor scores. Duncan's Multiple Range Test was performed to evaluate whether there were significant differences in mean scores between each demographic variable sub-group on the 12 sub-scales of the job satisfaction questionnaire.

4.3.2 (Cont'd)

The scores obtained from each of the 12 questionnaire sub-sections (accomplishement, recognition decision-making, utilization of knowledge and skills, educational opportunity, promotional advancement, pay, workload, scheduling, unit size and function, job-related communication and kinship) were analyzed with each of the previously identified demographic variables. Tables 2-13 summarize the scores for each of the sub-sections by the demographic variables identified as significant.

The analysis of the thirteen sub-sections of the questionnaire, with significant demographic variables, indicates that employing facility (hospital, nursing home or community nursing), hospital size (large, medium or small), area of employment (administration, special care or general) and rotation worked (either yes or no) are the most consistent predictors of satisfaction in regard to the thirteen sub-sections examined. Although other demographic variables are identified as having a significant effect on each sub-section area, these four factors occur more frequently than all others. It is therefore concluded, based on these findings, that those employed in hospitals of a medium size, are in general nursing and who work rotation, are influenced more by factors effecting quality of worklife than are other nurses.

It is to be noted, that this analysis (Tables 2 to 13) presents demographic means and probabilities only indicative of their relationship to the specified variable. The scores are not representative of the 13 sub-section areas relationship to job satisfaction.

Table 2
Accomplishment Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Age	3.43	3.43	0.001
Age of Youngest Child	3.44	2.09	0.050
First Language	3.44	5.20	0.020
Employing Facility	3.43	22.37	0.001
Hospital Size	3.32	3.54	0.030
Area of Employment	3.42	3.33	0.010
Current Position	3.42	4.08	0.010
Type of Nursing	3.40	7.17	0.007
Rotation	3.43	10.09	0.001
Shift	3.50	6.64	0.001

Table 3

Recognition Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Marital Status	3.37	8.59	0.0036
Employing Facility	3.36	5.37	0.0050
Education	3.35	4.36	0.0135

Table 4

Decision-Making Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Employing Facility	3.25	8.51	0.0002
Hospital Size	3.22	7.51	0.0007
Education	3.26	3.04	0.0491

Table 5

Utilization of Knowledge and Skill Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Employing Facility	3.25	11.22	0.0001
Hospital Size	3.18	4.92	0.0079
Area of Employment	3.24	3.24	0.0405
Type of Nursing	3.22	4.90	0.0278
Rotation	3.25	4.84	0.0285

Table 6
Educational Opportunity Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Employing Facility	3.15	5.35	0.0051
Hospital Size	3.12	8.79	0.0002
Area of Employment	3.17	5.54	0.0043
Current Position	3.15	6.46	0.0018
Rotation	3.15	3.98	0.0468
Salary	3.15	2.87	0.0582

Table 7

Promotional Advancement Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Marital Status	2.68	6.09	0.0141
First Language	2.67	8.24	0.0043
Employing Facility	2.67	8.66	0.0002
Hospital Size	2.70	21.19	0.0001
Area of Employment	2.67	4.44	0.0126
Type of Nursing	2.68	8.44	0.0040
Caseload	2.70	2.96	0.0128

Table 8
Pay Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
First Language	2.40	5.75	0.0170
Employing Facility	2.40	20.98	0.0001
Hospital Size	2.31	14.93	0.0001
Area of Employment	2.40	8.38	0.0003
Caseload	2.28	3.22	0.0077
Rotation	2.41	11.01	0.0010
Salary	2.38	4.72	0.0095

Table 9
Workload Scores with Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Age	3.30	2.65	0.0110
Employing Faciligy	3.30	5.45	0.0046
Hospital Size	3.27	4.10	0.0176
Caseload	3.24	3.69	0.0031

Table 10
Scheduling Scores With
Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Age	3.57	5.11	0.0001
Age of Children	3.56	2.96	0.0078
First Language	3.56	15.82	0.0001
Employed as R.N. (currently)	3.57	4.43	0.0361
Employing Facility	3.57	5.38	0.0050
Area of Employment	3.59	4.58	0.0109
Years as an R.N.	3.56	3.55	0.0038
Current Position	3.56	6.54	0.0016
Rotation	3.57	36.76	0.0001
Shift	3.75	4.39	0.0138
Hours	3.57	2.71	0.0680
Salary	3.58	5.49	0.0045

Table 11

Unit Size and Function Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
First Language	3.01	41.06	0.0001
Hospital Size	2.98	15.00	0.0001
Type of Nursing	2.98	5.34	0.0216

Table 12
Job Related Communication Scores
With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Marital Status	3.28	9.08	0.028
Employing Facility	3.27	6.99	0.0010
Rotation	3.28	12.94	0.0004
Shift	3.37	3.42	0.0350

Table 13
Kinship Scores With Significant Demographic Variables

Demographic Variable Name	Mean Score (5 possible)	F Value	Significance (P Value)
Age	2.75	5.69	0.0001
Age of Children	2.75	4.89	0.0001
Employing Facility	2.75	3.57	0.0290
Years as an R.N.	2.76	5.22	0.0001
Current Position	2.75	9.12	0.0001
Rotation	2.75	5.28	0.0221

4.4 Test Reliability

Reliability refers to the ability of a given test instrument to obtain consistent scores from subjects being examined. Table 14 presents the reliability coefficients for each of the thirteen sub-sections of the questionnaire and identifies their strength in measuring job satisfaction. The closer reliability scores get to 1.0 the more reliable they are considered.

The results of the analysis, presented in Table 14, indicates that the factors of pay, promotional advancement and kinship had the greatest effect on quality of worklife assessment. Each of the other factors identified possess mean scores which are not significantly different from one another, thus it is concluded that the factors of pay, promotional advancement and kinship are the primary predictors of job dissatisfaction in this component of the analysis.

In conclusion, the test instrument had an overall reliability of .8063 which is indicative of its effectiveness in consistently measuring job satisfaction.

4.5 Discussion

The overall analysis indicated that New Brunswick nurses are generally more satisfied than dissatisfied with their working conditions. As is explained in the Tables presented, however, there are specific areas: pay, promotional opportunity, kinship, scheduling, educational opportunity and decision-making, which are bordering on relative levels of dissatisfaction. It is assessed that these factors need be addressed to avoid further deterioration.

Table 14
Determinants of Nurses' Job Satisfaction

Variable	Mean Score	Standard Deviation	Reliability
Accomplishments (Five items)	3.41	0.6522	0.7401
Recognition (Five items)	3.33	0.7367	0.6175
Decision-making (Five items)	3.25	0.5518	0.5087
Utilization of Knowledge and Skills (Four items	3.25	0.7039	0.5014
Educational Opportunity (Five items)	3.13	0.7224	0.5625
Promotional Advancement (Three items)	2.70	0.9414	0.6460
Pay (two itmes)	2.40	1.1015	0.6932
Workload (Seven items)	3.29	0.6179	0.7000
Scheduling (Seven items)	3.01	0.7756	0.6878
Unit Size and Function (Five items)	3.57	0.6834	0.4672
Job-Related Communications (Six items)	3.27	0.7638	0.6765
Kinship (Three items)	2.73	0.7230	0.1823

5. FOCUS GROUPS

5.1 Method

5.1.1 Subjects

The subjects were 104 practising nurses (including those employed full-time, part-time and casual), selected from the full range of health care delivery agencies. A total of 12 mixed groups, (two per region except one in Regions 3 and 7). The intent was to conduct two groups in Region 3, however, lack of cooperation made it impossible to organize a group in the northern area of this region. Two-thirds of the participants were from hospitals, 10 percent from nursing homes, 20 percent from community nursing and 4 percent from psychiatric hospitals.

From hospitals, nurses involved worked in all types of units (intensive care, pediatrics, psychiatry, operating room, out-patient/emergency, medical/ surgical, chronic and maternity). These nurses represented regional, district and community hospitals in each region.

From psychiatric hospitals, nurses represented the three major patient categories (active treatment, rehabilitation and long term).

From nursing homes, nurses were from both large and small homes.

5.1.1 (Cont'd)

From community services (public health, community mental health, extramural, private physicians' offices, VON, corrections, industry, health service centres and alcohol and drug treatment).

Participants were selected within each category with the assistance of nursing managers. The general procedure for selection was to request these persons to provide three names of nurses from their staffing lists whose position on the list corresponded to the random numbers selected by the researcher. The focus group organizer then arranged for the participation of one of the three.

However, in approximately 25 percent of the cases, neither one of the three was available. In these cases, the nurse managers involved were again contacted and requested to arrange the participation of a substitute from the relevant category.

5.1.2 Materials

The apparatus used in this phase of study consisted of the previously described job satisfaction questionnaire and a Moderator's Guide.

The Moderator's Guide (see Appendix D) was designed as a resource for examination of specific topics in group discussions. Divided in two sections, 1) factors effecting job satisfaction and 2) potential future actions, this instrument provided a constant base for information retrieval. The first section of the guide included probes regarding accomplishment, recognition, decision-making,

5.1.2 (Cont'd)

utilization of knowledge and skills, educational opportunity, promotional advancement, pay, workload, scheduling, unit size and function, job-related communication and kinship. The section dealing with potential future actions presented characteristics of established interventions, such as job sharing, the Baylor Plan and the Clinical Ladder, in an effort to identify factors that are necessary for potential program success.

It is to be noted that a cassette recorder was used in each focus group, with participant's permission, in an effort to obtain all information provided and to ensure its accuracy.

5.2 Procedure

In this research phase all focus groups were conducted using the same format, regardless of the language (English or French) in which the session was conducted. Participants, upon entering the room were asked to complete the questionnaire examining quality of worklife issues. Subjects were asked to begin at section II of the questionnaire and then return to section I for completion. This procedure was employed in an effort to reduce subjects being influenced by the following discussion. Upon return, questionnaires were enclosed in sealed envelopes to ensure participants anonymity. Following the completion of this task the group was introduced to the Moderator and the recorder and a brief explanation of the study was provided. Discussion then began on the topics outlined in

5.2 (Cont'd)

the Moderator's Guide and participants were asked to present their views and opinions freely and honestly. Confidentiality was again assured. Conduction of each group encompassed a three-hour period and concluded with an opportunity for participants to make final comments.

5.3 Results

The information obtained from the focus groups was analyzed by subject according to the variable ordering in Table 1 and the questionnaire section of this report. In addition a comprehensive examination of suggested solutions is presented.

5.3.1 Factors Affecting Job Satisfaction

The majority of focus group participants indicated a high level of dissatisfaction with the current situation among nurses in New Brunswick. It was generally explained that although they "liked" nursing they would not have considered it as a profession if they had known "what they now know". Most participants agreed that they would hesitate to recommend this field to a young person asking their advice. It was felt that unless the present situation was drastically changed there would be few people interested in entering the profession and the difficulty in maintaining those presently employed in the field would increase. As indicated by one group of participants, "as it stands now, the reality of nurses worklife is such that it will not attract quality candidates or secure those already in nursing".

5.3.1 (Cont'd)

A minority of participants indicated that they would encourage others to enter the field of nursing, even under the present circumstances, however, they specified that they would strongly recommend that the individual enroll in a Baccalaureate Program, as this would provide them with more job freedom in the future.

This introduction provides a general overview of the feelings experienced by nurses in New Brunswick in regard to their job situations. Further analysis was conducted with specific factors affecting job satisfaction. The results are described in the following:

Accomplishment

Accomplishment has been identified as the attainment of personally defined goals within the work environment. In regard to this element, focus group participants identified the provision of quality patient care including proper psycho-social care and patient teaching, as a primary personal goal, however the majority of participants felt that this goal was relatively unattainable. This situation was described most frequently among the focus group participants who were employed in large hospitals. Nurses feel that, due to their excessive workloads, they are unable to spend enough time with patients, and therefore can not provide the proper care. As indicated by one respondent "nursing school taught us how satisfactory patient care could be and that

5.3.1 (Cont'd)

this would provide a sense of personal accomplishment - the reality of being unable to provide this care was a shock". Nurses in the groups indicated the importance of experiencing a sense of accomplishment in regard to their work, yet appeared highly dissatisfied with conditions that interfered with obtaining this experience.

Exceptions regarding this assessment of accomplishment were identified by a number of nurses working in areas other than the hospital. These individuals felt that due to the structure of their employing facilities more time was allotted for patient care and thus their sense of accomplishment was greater than those employed in hospitals.

Recognition

For the purpose of this study recognition was defined as the acknowledgement of quality care provided and of the efficient execution of duties by administrators and co-workers. This included evaluation of performance, reward and reprimand. Participants questioned, regarding this variable's function, provided varying information, however, with few exceptions, nurses identified patients, co-workers and, to some degree, head nurses as the sources of the majority of positive feedback about their work.

5.3.1 (Cont'd)

In regard to performance evaluations nurses employed in hospitals indicated that regular evaluations of their work were rarely conducted. Some participants had been employed as R.N.'s for 13 -15 years and had never been evaluated. Among the group of hospital nurses, the consensus was that these evaluations were not useful, as they are designed to examine negative rather than positive attributes, and therefore provided mostly negative feedback. The majority of these nurses felt they received little recognition based on performance evaluations.

Among nurses employed in nursing homes, no consistent trend was observed. Some had received performance evaluations on a regular basis, others had not, however, their assessment of such tools usefulness was supportive of that indicated by hospital nurses.

Those participants representing community nursing were evaluated on a yearly basis, yet most felt the procedure was not adequate.

The major complaints, shared by most nurses in the three groups (hospitals, nursing homes and community nursing), regarding performance evaluations included nurse's dissatisfaction with the regularity of evaluation, limitations of the evaluation instrument, the use of one measure to assess all nurses and the lack of personal assessment by the head nurse.

5.3.1 (Cont'd)

To improve this process nurses felt that a regular evaluation should be conducted which included both a written evaluation and personal interviews with the head nurse, to discuss any problems and to provide positive feedback directly.

Decision-Making

Decision-Making refers to the level of ability to assist in decision-making regarding patient treatment and facility operation. A minimum of information was provided by focus group participants regarding this specific topic, however comments made in connection with other topics presented tend to reflect the level of satisfaction experienced in regard to this variable. Of those nurses addressing this subject specifically, the majority felt that they had inadequate input into decisions surrounding patient care and facility operation. Participants explained that because so many decisions made either directly or indirectly effect them and their ability to provide quality care, that their opinions should be sought, however in the majority of cases this practise is not employed. Poor communication, between nurses, supervisory and administrative staff, was identified as a primary deterrent to nurses' participation in the decision-making process.

Utilization of Knowledge and Skill

This factor can be defined as the ability to exchange knowledge and skills with colleagues. Nurses, in the focus groups, explained that there was some opportunity to share knowledge with their

5.3.1 (Cont'd)

colleagues, however this practise was rarely encouraged by supervisory staff in hospitals or nursing homes. Lack of time was considered to be the greatest obstacle to the conduction of this practise. As one intensive care nurse explained "we rarely have time to complete our required work; time for "sharing" with colleagues is almost non-existent". All nurses interviewed felt that sharing of knowledge and skills was important, however it appeared that generally only those in Community Nursing were provided with such opportunities and supported for so doing.

Educational Opportunity

The ability to participate in educational programs and to increase expertise, with support (via time, availability, rescheduling) from the employing facility has been identified, in the literature, as a relatively important factor in nurses' job satisfaction assessment. Nurses questioned regarding this factor provided a wide variety of information. Hospital nurses differed greatly in their assessment of opportunities and support in furthering their education. Many felt that it was difficult to attend classes when working shifts, especially where there is no opportunity for rescheduling. These individuals explained that in their facilities the responsibility of scheduling, financing and arranging for attendance in educational programs was the responsibility of the nurse. Minimal support was given by the facility.

5.3.1 (Cont'd)

Minimal information was provided by nursing home employees in regard to this factor, however those who did respond indicated that their facility was very supportive of furthering education and assisted such endeavors through the provision of "time-off" and financial aid.

Community nurses described their situation as highly similar to those employed in nursing homes, in regard to education opportunity.

Promotional Advancement

Promotional advancement, or the opportunity for progression within the work environment, is an area of considerable concern to nurses at present. The majority of focus group participants, regardless of the area of employment (hospital, nursing home or community nursing), indicated a high level of dissatisfaction with current promotional opportunities. As explained by participants, there is minimal opportunity for advancement in nursing unless you meet one or more of the following criteria: 1) you have seniority; 2) you possess a Bachelor of Nursing or Masters degree; ;and 3) you are Bilingual. Many respondents felt that these requirements were unfair and that they promoted negative feelings among nurses not meeting these standards. As one hospital representative indicated "with requirements of this type, and need for promotional advancement, many nurses feel trapped because for them there is little chance of job mobility.

5.3.1 (Cont'd)

Pay

The variable of pay has been defined as the financial rewards received for work conducted. The majority of participants examined felt that the salary they received was inadequate in comparison to the responsibility their jobs entail. These individuals believed that more benefits should be made available such as higher pay levels for those working undesirable shifts, better pension plans, and extended maternity leave, all of which should be provided to both full and part-time staff. Although a high level of discontent was indicated by focus group participants regarding the adequacy of their salaries, there was almost unanimous agreement that improved working conditions would be far more appreciated than salary increases.

Workload

Workload has been defined as the extent to which job demands are either too high or too low. Most of the nurses examined felt that they are overworked to the point where they are often unable to provide quality care to their patients. These individuals believe that increased caseloads, the performance of activities not directed toward patient care and the increased amount of paperwork that must be done all contribute to the ever heightening demands being placed on nurses at present. In addition to the increasing

5.3.1 (Cont'd)

demands of nursing it was noted that there are sometimes fewer nurses available to adequately meet the individual facility's needs. As a result of this there is often a disproportionate amount of work being allotted to a few individuals.

Scheduling

For the purpose of this study scheduling has been used to denote the preferential selection of shift and work period, and the dependence of this flexibility on adequate staffing. Information obtained from focus group participants varied widely regarding this topic, and depended greatly on individual circumstances, however a major area of commonality was observed. Most respondents indicated that their greatest concern regarding scheduling surrounded their inability to participate in schedule design. As a result of this lack of input, individuals felt that neither their personal or professional needs were considered when the schedules were created. Where options and/or flexibility have been offered nurses, dissatisfaction has been assessed to a lesser degree than where rigidity exists and central scheduling is employed.

To improve this situation, participants suggested employing a system of scheduling which allows for greater input by those directly affected.

5.3.1 (Cont'd)

Unit Size and Function

Unit Size and Function refers to the operational scale of the institution; the availability of modern equipment; the size of the facility in relationship to community needs; and the locations accessibility. Most focus group participants felt that their employing facilities were generally satisfactory. Those who were dissatisfied with their institutions attributed the problems to patient over crowding, the mixing of patients within units and inadequate training in the use of new equipment. As indicated by these participants it is common, in some areas, to see patients left on stretchers in halls because there are no rooms available. This practise nurses feel is both dangerous to the patients and stress-inducing for the staff.

The majority of nurses interviewed feel that the best solution to these problems is for administration to seek their advice when planning hospital/facility renovations or changes. This would provide information which could better accommodate both staff and patients.

5.3.1 (Cont'd)

Job-Related Communications

Job-Related communications refers to the interaction between nurses, peers, administration and physicians. In regard to this topic focus group responses indicated that relationships were often based largely on the individuals involved. Most nurses felt that their relationships with other nurses and co-workers were positive and indicated that a great deal of support is derived from these channels. In regard to their relations with Nursing Administrators the concensus was that nurses feel these individuals 'try' but they are too far removed from the situation in most cases. Nurses relationships with physicians and other professionals were assessed with maximum variations, however, the general opinion was that these individuals do not fully respect the profession of nursing, which results in sometimes strained relations between these groups.

Kinship

For the purpose of this study Kinship was identified as the willingness of the employing facility to accommodate family and/or personal needs and responsibilities.

The majority of focus group participants indicated that as nurses their family and personal lives are often stressful. As a result of changing schedules nurses feel that it is very difficult to meet both

5.3.1 (Cont'd)

family and social obligations; and the inflexibility of their schedules serves only to further their dilemna . Nurses with young children explained the difficulties of finding child care services which meet the requirements of shift demands.

Most participants agreed that increased flexibility regarding scheduling would improve their present situations.

5.3.2 Potential Solutions

Focus group participants were presented with descriptions of numerous approaches, dealing with innovative staffing measures; supportive work environment measures; participation in the decision making process: communication, independent/expanded function of the nurse; promotional opportunity; and basic training programs, (See Appendix E) which have been attempted in various settings in an effort to improve nurses' quality of worklife. In response to these approaches, the majority of participants indicated that they were supportive of most proposed solutions.

It was expressed that Twinning or Job Sharing was a must for nurses. This approach would allow nurses more flexibility in their work schedules without the usual loss of benefits. It was felt that Job Sharing may prevent nurses who are unable to work full-time, yet still wish to work, from terminating their employment.

5.3.2 (Cont'd)

Most participants felt that the Baylor Plan had great potential, however, it was as a rather idealistic all encompassing solution to scheduling problems, given the present situation.

Extra time for vacations taken during winter was thought to be a very positive measure when employed as an incentive. Nurses believed that this approach may decrease existing dissatisfaction with vacation scheduling.

Primary nursing received little support as participants felt that the present shortage of nurses would make such an endeavor impractical at this time.

The concept of the Clinical Ladder Program received almost unanimous support, as it would potentially allow for advancement, an area of great importance to nurses.

A Selection Process based on unit or program specific job descriptions was felt by most nurses to possess a certain value however, the consensus was that it may cause some nurses "to lose their only way out" - seniority.

The concepts of: communication, availability of a resource person, informal contacts with administration, exchange programs, management courses, assertiveness training and stress workshops, 24-hour child care services, extended

5.3.2 (Cont'd)

maternity leave, sabbatical leave, and patient classification systems, were all viewed favorably as each could potentially reduce job dissatisfaction in some way.

One of the most common suggestions, put forth by nurses themselves, dealt with relations with administration and nurse managers. The majority of participants felt that upper and middle level management should "listen more to nurses", attempt to understand nurses' needs and take as valuable the suggestions nurses make regarding patient care, hospital function, and their own schedules.

6. INTERVIEWS

6.1 Method

6.1.1 Subjects

The participants involved in this research phase included 51 individuals representing head nurses, nursing supervisors, directors of nursing, administrators, union representatives and association representatives. Facility and nursing managers were selected from randomly identified facilities in each region. The names of union and association representatives in each region were provided by the NBNU and NANB. Each of these individuals was interviewed in person.

6.1.2 Materials

The materials used in this research phase consisted of an interview guide. This guide contained 34 items examining accomplishment, recognition, decision-making, utilization of knowledge and skills, educational opportunity, promotional advancement, pay, workload, scheduling, unit size and function, job-related communications and kinship.

6.1.3 Procedure

Subjects were contacted by phone and arrangements were made for the interview time and location. At the time of the meeting, the interviewer briefly explained the nature and purpose of the study and then presented the questions in the guide, for subject response.

In all cases, confidentiality was assured.

6.2 Results

6.2.1 Recognition of the Problem

The information obtained from individual interviews indicated that the majority of participants felt that generally, nurses in New Brunswick are dissatisfied with their quality of worklife. This finding was consistent throughout each of the interviewed factions, and disagreement was seen primarily among those who were not directly involved with nurses at a working level. Nurses employed in Nursing Homes and/or Community Nursing were perceived as experiencing less job dissatisfaction than those employed in hospitals, however no one group was identified as immune to the factors which contribute to job dissatisfaction.

Knowledge of the Major Factors Contributing to Job Dissatisfaction

A variety of factors were identified by those interviewed, as contributing to job dissatisfaction among nurses however, workload, recognition and scheduling were viewed as the major factors effecting quality of work assessment.

In regard to workload, the majority of participants explained that increased caseloads and decreased staffing have created almost unbearably heavy workload for many nurses.

6.2.1 (Cont'd)

Although, as identified, support staff such as orderlies, R.N.A.'s and the like, do attempt to lighten the workload, nurses are still unable to adequately meet the physical and emotional needs of the many patients to which they are assigned.

Recognition was also identified as an area of concern among nurses by these participants. As explained, nurses rarely receive enough recognition when they have done a "good job" yet receive immediate reprimand when they have failed to fill their role. This situation was felt by most participants, to create a feeling of "not being valued" among nurses and definitely can affect their job performance.

In regard to scheduling, the majority of interviews indicated that in most cases nurses are presented with centrally designed schedules which do not take into account the personal needs of the employees. This lack of input into scheduling, the erratic shifts and rotations worked were all assessed as having a highly negative effect on nurses.

6.2.2 Proposed Solutions

The subjects were presented with descriptions of a number of potential solutions and the majority considered the following programs positive interventions:

- The Baylor Plan
- Job sharing
- Winter vacations

6.2.2 (Cont'd)

- Clinical ladder
- Opinion survey
- Communication - upward, downward, lateral
- Exchange programs
- Day care.

Each of these programs was viewed as having strong potential for improving quality of worklife among nurses. However, it was noted that the success of any approach would be based on its ability to adapt to the specific needs of the setting in which it would be implemented.

Other suggestions put forth regarding potential solutions included payment of sick time not taken, pension adjustments and decentralization of scheduling.

It is particularly important to report on the observations by nursing managers concerning their own problems and needs. As a group, they are concerned about inadequate opportunities to participate in overall facility/agency management activities, either as members of executive management or through direct involvement with boards of directors. In addition, they recognize their needs for formal management training.

6.2.3 Feasibility of Implementation

The majority of participants indicated that all of the potential solutions described had some merit. However, those which required possible changes in staffing, such as extended maternity leave and sabbatical leave, were seen as less feasible at this time. Due to the shortage of "working nurses" programs wherein nurses are relieved of duty for extended periods are almost impossible to implement. In essence, these individuals "cannot be spared".

All other programs were seen as feasible, yet not in all cases.

As previously indicated, it was felt that the program must fit the needs of the given institution or facility in order to be effective.

The majority of interviewees indicated a great need for changes that would result in quality of worklife improvement for nurses. However, they have not clearly demonstrated their commitment to lead in the implementation of worklife improvements. Of particular concern is the indication that nurse managers appear no more committed to fostering change than those less directly involved.

6.3 Method

6.3.1 Subjects

In addition to interviews with individual nurses and administrators, meetings were held with representatives of eight organizations with a high level of interest in nursing concerns, including:

- The President and Executive Director of the New Brunswick Nurses Union
- The President and Executive Director of the Nurses Association of New Brunswick
- The President of the Management Nurses Association
- The President, members of the Board and the Executive Director of the Association of New Brunswick Registered Nursing Assistants
- The senior staff of the New Brunswick Hospital Association
- Members of the faculties of one diploma and one University School of Nursing
- The Board of Management's negotiator for the nurses collective agreements
- Nursing consultants and other head office staff with professional nursing qualifications in the Department of Health and Community Services.

6.3.2 Apparatus and Procedure

The materials and procedures employed in this research phase were identical to those used in individual interviews.

6.3.3 Results

The input from the New Brunswick Nurses Union and the Nurses Association of New Brunswick were obtained in written documents and in discussions based on their content. They are appended to this report (see Appendices F and G). It is encouraging that the problem descriptions and recommendations for change from these groups are notably similar. In addition, this material was generally consistent with the findings of other components of the research undertaken in this study. The level of concern and willingness to participate in positive changes in the workplace are high among both organizations representing nurses in New Brunswick.

Other participants offered a broad range of comments that add support to the information obtained from nurses employed in service delivery. These comments have been grouped in seven categories, as follows:

Recognition

- There is little recognition of nurses capabilities
- Understanding of and support is often lacking for the multiple roles that nurses with family responsibilities often must perform

Management

- The management approaches of nurse managers and other managers in health care need to be reviewed
- Nurse managers are not prepared to manage change

6.3.3 (Cont'd)

- Nurse managers are out of touch with staff nurses and the stresses they face
- Management is not acting quickly enough to avoid the development of problems created by shortages
- Change has to come from within and be directly lead by management
- It is difficult for managers with an RN only to provide leadership to baccalaureate nurses
- Head nurses are in a conflict situation as providers of direct care, first line managers and members of the same union as their staff.

Education

- A lack of nurses with enough expertise may be more important than overall nursing numbers
- Nurses need education to be able to delegate effectively
- Basic diploma and degree programs are flawed.

Workload

- Nurses are reaching their coping limits
- Hospital occupancy rates are running above 85 percent, the reference level for nursing staffing standards
- There has been no change to staffing standards for nurses to reflect changing patient profiles since 1979
- A large number of inexperienced nurses are given too much responsibility too soon
- There is a need for effective workload measurement tools
- Patients often complain about insufficient personal care, not specifically nursing care.

6.3.3 (Cont'd)

Compensation

- Currently rewards and incentives are for moving away from the bedside
- Money alone will not solve the problems.

Physical Facilities

- Often there is no place where nurses can go to let off steam
- Head nurses should have offices.

General

- Conflict between the association and the union on specific issues reduces the impact of these representative organizations
- Nurses at all levels feel shutout
- The factors that effect the quality of working life for nurses also impact similarily on other staff involved in delivering health care services
- Nursing contract negotiations should follow a new style involving joint problem-solving with the active participation of nurse managers.

7. CONCLUSIONS

7.1 Work Environment

While the level of nursing job satisfaction in New Brunswick is still generally high, and drastic corrective measures are not required, it would be inappropriate to conclude that the nursing work place is not in need of improvement. It is fortunate that the many difficulties that nurses experience have not, to date, resulted in significant job dissatisfaction. It would be unwise, however, to assume that this situation will persist.

Stated in different terms, the nursing worklife environment in New Brunswick is not bad, but neither is it as good as it could or should be.

Quantitatively, as measured in the mail survey segment of our research, the problems are not great. However, our qualitative impressions from the focus groups and interviews suggest that job satisfaction will deteriorate without the creation of more positive work environments.

As job dissatisfaction is a major reason that nurses resign, turnover can be reduced by adjusting the working conditions that contribute to this dissatisfaction (Weisman, 1982).

Consequently a preventive approach is proposed, that will not only reverse deterioration in the quality of nursing worklife, but result in measureable and expressed improvements.

7.2. Improvement Priorities

Taken together our findings indicate that three areas cause the most aggravation for nurses at all levels. These are decision-making, compensation and scheduling. While some of the recommendations made in this report touch on other areas, attention to these major factors is likely to have the greatest impact on nurses' job satisfaction.

It is important to note that there are numerous examples in the province of practises that enhance the worklife of nurses. The concern is that there are too many situations in which rigid approaches exist, particularly in the areas of decision-making, scheduling, and the facilitation of continuing education.

7.3 Labour Force Participation and Nursing Supply

There is not a shortage of nurses in New Brunswick. Rather there is a shortage of nurses willing to work under the conditions that prevail in some settings. Maintaining the rigid approaches to recruitment and scheduling, in an attempt to obtain the maximum involvement of existing staff will contribute to more practising nurses opting out of practise or choosing different work places and will discourage inactive nurses from reentering practise.

It is becoming increasingly important, as well, to recognize that New Brunswick's nursing workforce is viewed as potential employees by health care services throughout North America. Incentives to relocate can be extremely attractive. While this is likely to primarily affect new graduates, the provincial health care system cannot afford to overlook the need to remain competitive. These new graduates will be needed to fill positions in New Brunswick.

7.4 Readiness of the System to Change

Attitudes, knowledge and flexibility are the key attributes that will determine the extent to which the system is prepared to change and the rate at which change will occur.

Attitudes relate to the way in which nursing roles are perceived both within the profession itself and among others who employ, interact with or represent nurses.

Flexibility refers to the extent to which nurses themselves, the organizations that represent them, and their employers are prepared to recognize and act on the reality that many nurses throughout their careers must seek a balance between their family, practise and educational responsibilities.

Knowledge is important as a foundation for identifying what needs to be changed, the approaches that could have a positive impact and the methods to implement these approaches.

At the most strategic level, the provincial government, it is noteworthy that the Minister of Health and Community Services has recognized the importance of nursing resources by establishing the Nursing Resources Advisory Committee. The Minister's decision, in response to a recommendation from the Nursing Resources Advisory Committee, to undertake this study is further evidence that here is a willingness to address the need for nursing worklife improvements.

The interest shown by all individuals and organizations who participated in the project indicates that there is considerable willingness to change and an existing base of knowledge about many of the improvements that would enhance

7.4 (Cont'd)

nursing worklife. A significant finding is the extent of consensus among the major organizations (New Brunswick Hospital Association, Nurses Association of New Brunswick and New Brunswick Nurses Union) regarding the importance of "professionalizing" nursing practise and nursing administration. The briefs from the Union (New Brunswick Nurses Union) and the Association (Nurses Association of New Brunswick) appended to this report can be characterized by the extent of common ground that unites the organizations that represent nurses, rather than any major differences that place them in conflict.

The New Brunswick Hospital Association can have a significant effect on the attitudes and knowledge of Board members and administrative staff and, according to their staff, are prepared to play an active role in assisting hospitals with the change process.

8. RECOMMENDATIONS

8.1 Recommendation # 1 - Decision-Making

It is recommended:

That decentralized, participative management approaches be encouraged to increase the involvement of nurses at all levels in decision-making affecting their practise.

Functional autonomy to make nursing decisions remains beyond the reach of most nurses (Attridge et al., 1987:36). In most New Brunswick health care agencies, as elsewhere, nurses have little input or involvement in major institutional policy decisions, such as the introduction of new services and the planning of new units or programs that may have a direct impact on their work. In some institutions, nurses do not even participate in the selection process of the Director of Nursing and are not represented at meetings of the agency's board of directors. "Nurses and nursing have the potential and are prepared to be part of the solution to delivering cost effective health care." (AARN, 1988:iv) They can be an invaluable resource to management. Increased autonomy and responsibility are central goals driving nursing's quest for professionalism (Allen et al., 1988) and nurses are seeking means to be more independent and autonomous (Peterson, 1983).

To address the problem of nurses' dissatisfaction with the degree of control they have over working conditions and the work process, re-thinking of the fundamental nature of nursing work and the traditional employee-employer

8.1 (Cont'd)

relationship between health care agencies and nurses will be required. Specific changes in the organizational structure of many of these health care agencies will have to occur. If this does not happen these agencies will not benefit from the full contribution that nurses can make, and the quality of patient care will not reach the level it should.

Some theoretical and conceptual models have been proposed as having particular relevance for nursing administration. The literature, however, is increasingly advocating decentralization, participative management and shared governance as means for improving organizational performance and making nurses professional practise more complimentary with organizational goals. (Allen et at, 1988; Shoemaker et al, 1983; Smith, 1988). Such models would, in the view of some experts (Weisman, 1982), give more control and autonomy to nurses and help them draw more satisfaction from their work environment (Allen et al, 1988; Shoemaker et al, 1983).

There are several reasons for advocating decentralization of authority in health care agencies. Shoemaker and his colleagues (1983) suggest that decentralization promotes a more democratic organization in which management authority is shared among staff. This reorganization is being pushed by both progressive nursing leaders and hospital administrators, who are themselves being encouraged by consumer groups and government. The authors believe that decentralization improves the quality of managerial decisions and thus can have a positive effect on the financial performance of facilities. It can also

8.1 (Cont'd)

significantly reduce absenteeism and increase productivity (Andrew et al., 1983). Communication and trust is also improved through shared governance and the delegation of responsibility and authority for management action in a downward direction (Peterson, 1983).

Whereas a highly centralized organization is one in which most decision-making power is retained by the chief executive, decentralization refers to the spreading out of authority, responsibility and decision making to members of an organization other than the dominant executive (Shoemaker et al, 1983). In a decentralized system or participative management decision-making is diffused throughout the organization. The retention of major decision-making by a few nurses' administrators in the centralized model tends to keep nurses passive and unenthusiastic about their work.

To encourage a shift toward decentralization of authority, the following actions should be addressed:

1. Motivate staff nurses to actively participate in making nursing decisions and in making their work environment better suited to meet the needs of their clients and themselves.

2. Develop trust between nursing administration and staff and instill the message that involvement will make a difference.

8.1 (Cont'd)

3. Allow for creativity, experimentation and risk taking (Kramer et al., 1988) at the unit level.

4. Provide head nurses/unit managers with a span of control which would allow her to have full responsibility for human and financial resources involved with delivering services on her unit. This should be based on

   a) Patients profiles (level of activity, the immediacy of decision to be taken, level of coordination required and patient turnover;

   b) Nursing care programs (philosophy goals and objectives of the nursing department).

   c) Geographical contiguity (physical layout, etc.)

   d) Unit manager profile (her skills, experience and training)

   e) Employee profile (mix of staff, their training level and competence)

   f) Support system (unit clerks, clinical specialists, information system)

   g) Organizational factors such as size and complexity, stage of development as well as environmental factors (Alidina et al., 1988).

5. Provide head nurses/unit managers with a bargaining unit different than that of staff nurses to remove the current conflict resulting from membership in the same bargaining unit as those they are expected to direct.

8.1 (Cont'd)

6. Develop clear expectations for head nurses/unit managers and Directors of Nursing and support on-going continuing education programs to upgrade their knowledge and skills.

7. Make the Directors of Nursing directly accountable to the Executive Director of the health care agency, and enable them to communicate directly with the agency's board of directors.

8. Actively involve nursing in the agency's strategic planning process.

8.2 Recommendation #2 - Workload and Roles

It is recommended:

That safe nursing be established based on an agreed upon nursing conceptual model and on current nursing workload measurement.

It is generally acknowledged that nurses' workload has increased considerably in the last few years (AHQ., 1988; RNPBC, 1987). Employers have consistently increased their expectations and duties of registered nurses. It is as if they believe nurses can be stretched infinitely.

Hospitals tend to assign nurses with little regard to their individual skills and experience. Nurses are worried that clients will suffer if not provided with the nursing care they require and consequently they have accepted working longer hours with increased patient loads.

8.2 (Cont'd)

Although capable of doing a great deal, nurses simply cannot do every thing and management cannot continue to add to the load. The fatigue of nurses and their acceptance of assignments exceeding their competency can endanger patients. Furthermore, nurses have a right to a reasonable workload (Herman, S., 1978). Being legally responsible for the care they provide makes it extremely important that reasonable workloads be allocated. It is necessary to delineate exactly what services nurses will provide (Peplau, 1988).

They need to be clearer about their mission and goals in order to be able to say no to tasks that do not belong to nursing, without feeling guilty. This can be accomplished by the adoption of a nursing model in health care facilities. Nursing models provide nurses and their employing facility with a better understanding of the goals of the nursing profession, of the health care needs, individual patients, the nurses' role and activities as well as providing a basis for performance evaluation. Furthermore, underlying assumptions and values are also clarified in most nursing models. Nursing models are usually rooted in theory and in clinical practise (Fitzpatrick et al., 1983; Storch, J., 1987).

In order to make the model practical, the following guidelines are suggested. Each nursing unit should:

1) Develop standards of care for the unit based on the selected model.

2) Prepare operational guidelines

8.2 (Cont'd)

3) Carefully analyze skills and training required to meet care needs.

4) Decide on the most appropriate level of worker to be assigned for various functions.

5) Define appropriate policies and procedures.

6) Evaluate results.

The achievement of reasonable and safe workloads also necessitates the adoption of workload measures such as GRASP, Medicus or PRN. Such measures provide a basis for allocating nursing personnel to fit the constantly changing clientele profile. These processes for defining staffing requirements allow for nursing input and are flexible enough to adapt to fluctuations in the health status of clients, the evolution of technology and changes in standards of care. The tools are also useful in providing a rationale for increased staffing at budget time.

It is important to ensure that workload measurement systems are actively used. The use of the tool for the sole purpose of obtaining statistics has been frustrating to staff nurses who do not understand why such statistics are needed and why no additional staff is provided when the workload measures indicate that the unit is running short.

8.3 Recommendation # 3 - Recognition

It is recommended:

That there be recognition of knowledge and skills acquired by nurses through the application of the clinical ladder concept within the health care system.

8.3 (Cont'd)

"To thrive you have to have high expectations (Chenevert, 1985:3). As nurses and managers were interviewed during this research it became apparent that most New Brunswick health care facilities seem to consider nurses to be interchangeable. Nurses are seldom interviewed prior to filling a new position. Selection is often based solely on seniority.

New graduates who often occupy casual positions are utilized indiscriminately through the hospital as needs arise. Experienced nurses do not have opportunities to be promoted within the present system. They also do not have much incentive to change positions and practise in more complex or challenging units. The only way to progress as a nurse within the New Brunswick health care system is to either obtain an administrative/management position, or opt for a non-institutional position such as community nursing.

There is little promotional opportunity for nurses who would prefer to stay involved in a hospital-based clinical practise, there is nowhere to go. Yet nurses who have more experience are often expected to lead a team, to work with more difficult patients or to provide guidance to students and new graduates. Characteristically they comply as this provides them with some degree of challenge and excitement. It does not provide them, however, with financial rewards or even recognition.

One way to achieve excellence in nursing practise while promoting recognition and incentives is to institute the clinical ladder concept within the health care system. The concept, which is widely and successfully utilized in the United States (Barhyte, D., 1987; Metcalf et al., 1984;

8.3 (Cont'd)

Ives et al., 1975), and is being evaluated in Canada (Victoria General Hospital, Halifax, N.S.) offers nurses an opportunity for clinical promotion taking into account their educational background, demonstratable skills and relevant experience. As indicated by Metcalf and others (1984), the clinical ladder facilitates recognition of competency by peers, other professions and managers. Furthermore, the individual derives gratification in terms of more desirable or self-controlled working hours and financial rewards. They believe, satisfaction, in these two areas is a factor in staff retention.

With the trend toward specialization in nursing care it seems evident that nurses will need additional knowledge and skills. The need to obtain knowledge and skills must be recognized and valued by practitioners and employers if highly qualified clinical staff are to remain involved in direct patient care and support the work of less experienced personnel.

Following a clear identification of the role, responsibilities and level of authority expected of the nurse, as well as the expected standards of nursing care, nurses can move through several levels of competency and be paid accordingly (rather than being paid solely on the basis of seniority) in this system. Differentiation of clinical expertise is recognized in progressive levels of practise. These usually include a Level I which is the entry level for graduate nurses and nurses returning to work after an extended absence. Level II is the entry level for the majority of experienced nurses. The Level III position requires advanced clinical skills and demonstrated ability to assume responsibility for quality

8.3 (Cont'd)

nursing care delivery on a 24-hour basis. The top level is usually considered an expert practitioner. To qualify for this level, the nurse must demonstrate the skills and knowledge to provide sophisticated care to more complex cases. In addition, this nurse usually assumes the clinical specialist function for the unit.

Promotion of nurses on the clinical ladder is accomplished by a review board through a clinical appraisal and evaluation of attainment of established standards of knowledge and clinical performance. Nurses may apply for promotion whenever they consider themselves ready for the next clinical level. Means to improve practise, such as continuing education programs, are also identified and provided through this mechanism.

The clinical ladder concept, we believe, would provide for:

1) More dynamic/challenging clinical work environments for nurses.

2) Clinical support for less experienced nurses.

3) Financial rewards for increased ability and responsibility, (McDonagh et al., 1988).

4) Acknowledgement and recognition for acquisition of skills and knowledge.

5) More regular performance evaluation.

8.3 (Cont'd)

We, therefore, urge employers, the nurses association, and the union to:

1) Develop the clinical ladder concept in the N.B. health care system; and

2) Abolish the present system of automatic appointment based on seniority and ensure interviews are conducted to select the most competent nurse to fill vacant positions. This recommendation applies not only to the selection of clinical nurses, but to the selection of nursing managers as well.

8.4 Recommendation # 4 - Compensation

It is recommended:

That employers of nurses provide financial compensation consistent with levels of responsibility and variations in nursing working conditions.

Currently nursing compensation seems to primarily reflect the routine tasks performed. Little recognition is given for level of training, special abilities and judgement capacities or experience. Only minimal financial compensation is provided for education. Compressed salary scales offer no recognition for experienced nurses. Maximum salaries are reached in a few steps. In New Brunswick, the starting salary of hospital-based nurses is $22,207.00 per year and they reach a maximum salary of $26,993.00 after five (5) years. This means that a nurse who has twenty (20) years experience will receive the same salary as her nursing colleagues who worked for five (5) years and receive only $4,786.00 more per year than a new graduate ($2.65/hour more).

8.4 (Cont'd)

Furthermore, the differential compensation provided for less desirable shifts does not compensate for the inconveniences and added responsibilities involved. To reflect the level of responsibility involved in nursing as well as the working conditions that prevail, it is proposed that:

1) Salary be based on a clinical ladder concept (McDonagh et al., 1988).

2) More realistic differentials be paid to nurses who work inconvenient shifts such as evenings, nights, weekends and holidays.

8.5 Recommendation # 5 - Education

It is recommended:

That access to Continuing Education Programs be promoted through the provision of replacement budgets, the cooperative development of post-basic certificate programs and management courses as well as providing for an adequate orientation program and access to exchange programs.

> "Continuing Nursing Education refers to all learning activities that registered nurses undertake following basic nursing education to enhance nursing competency." (Alberta Association of R.N., 1988:19).

8.5 (Cont'd)

Continuing Nursing Education includes methods such as in-service programs, workshops and conferences, orientation of new nursing staff, degree programs as well as post basic certificates and self-directed learning activities.

To maintain and enhance their competency in an era of rapid evolution of scientific knowledge, technology and clinical practise in the health care field, it is essential that nurses be able to participate in continuing education programs. Nurses who are provided with adequate time for professional development tend to find more satisfaction at work (Weisman, 1982).

To allow nurses to participate in needed continuing education programs, priority should be placed by employers on providing an adequate replacement budget. Nurses believe that continuing education is a shared responsibility between themselves and the employer. They seem to be prepared to contribute financially but the difficulty in getting the time off appears to be especially problematic for nurses who work on a rotation schedule.

8.5.1 Post-Basic Courses and Nursing Degree Courses

As nursing is becoming less generic and increasingly specialized and as nurses often have the responsibility of providing services when physicians and other health care professionals are unavailable (evenings, nights, weekends and holidays), they need a broader skill base which includes interpersonal and technical skills as well as more scientific knowledge. The development of post-basic certificate programs in various nursing specialties is one of the answers. Programs designed for R.N.'s

8.5.1 (Cont'd)

who wish to complete a B.S.N. and that provide nurses with university credits are receiving a very favorable response from nurses and employers alike in New Brunswick.

It is therefore recommended that more post basic certificate programs for R.N.'s be developed by the two New Brunswick universities in collaboration with the New Brunswick Department of Health and Community Services and the Nurses Association of New Brunswick.

8.5.2 Orientation Programs

As the greatest number of nurses entering the various health care centres are either new graduates or nurses who have been absent from the nursing profession for a long period of time, it is important to safely initiate them into the workforce and to provide them with an orientation program aimed at reducing the "reality shock" (Kramer, 1974).

In this regard, we recommend that nurses be provided with an orientation program which is as tailored to individual needs as possible using self-assessment tools and various means for them to obtain the needed information and abilities to do their particular work safely. Furthermore, the utilization of a "buddy" system or a preceptorship for the on-unit initiation of these new employers would provide for safer care (Crout et al., 1984).

8.5.3 Exchange Program

To stimulate learning interests and to increase nurses' satisfaction as it relates to their opportunity to experience new challenges, health care services should implement exchange programs. This program is usually designed in a way that allows interested nurses to float to another unit when these become understaffed. The exchange nurse can apply to work on that unit for a 3 to 6 month period without losing her permanent position. Considerable coordination effort is required, but nurses who have experienced such an exchange often find it stimulating and valuable.

8.5.4 Management Courses

First line, middle and senior nurse managers in New Brunswick are normally selected for such positions on the basis of their excellent clinical skills or due to their seniority in the system. Nursing managers do not have (in most instances) an educational background which provides them with the knowledge and skills required to fulfill their managerial roles and responsibilities.

"Effective performance in the role of managers is critical to the provision of quality patient care." Effective functioning, in all health care agencies, is a complex undertaking requiring a broad range of clinical, organizational, leadership, human and conceptual knowledge skills (Alberta Association of R.N., 1988:25). It is vital that minimum educational standards for nursing managers be established, that nursing managers be involved in an

8.5.4 (Cont'd)

on-going management development program and that the work environment be conducive to the application of such knowledge. Nursing managers should also be encouraged to take health administration courses at the university level.

8.6 Recommendation # 6 - Family Responsibilities

It is recommended:

That kinship responsibilities be recognized by employing agencies by offering less traditional schedule options and a variety of leave of absence options (extended maternity leave, sabbatical leave, and deferred incomes).

The number of married women employed in nursing in Canada has steadily increased for the past 30 years. Whereas there used to be only one in four practising nurse while married in 1964, married women now make up over 70 percent of the Canadian nursing workforce (Baumgart, 1988:30).

It has long been recognized within the nursing profession that having a family and a nursing career is a difficult combination. This is especially due to the 24-hour, 7 day per week nature of most nursing employment which requires shift rotation on the part of the nurse. Because of schedules not filling the life pattern of their family, many nurses who are married and who have children are now seeking part-time employment. This permits them to be with their family before and after the school hours of their children and work hours of their husbands and during weekends and to attend to young children with a minimal requirement for babysitting arrangements.

8.6 (Cont'd)

It is also interesting to note that a greater number of single nurses are requesting part-time employment in the 1980's. They claim that their work schedule does not permit them to participate in their community/social life. Many would like to take on extra curricular activities such as evening courses but cannot do it due to the shift rotation at work.

To improve retention of this large workforce, it is imperative that employers consider less traditional methods to engage nurses' services. Job sharing is one concept which appeals to this group of nurses.

The advantage of such an arrangement is not only that it provides more time off to nurses who take on such positions, but that it also allows these nurses more control over the hours they work. Furthermore, by maintaining their benefits they feel that it is worth it for them to remain employed with their present employer.

As indicated, the work schedule of nurses who have the burden of child rearing can be quite problematic. This is experienced especially when babysitting arrangements are required during holidays such as Christmas, at night, on weekends, or during school hours when the school age child is ill and cannot attend school.

In order to limit the number of sick days and unplanned leaves taken by the group of employees and in order to provide these individuals with less stress related to having these dual responsibilities, it is recommended that employers examine the feasibility of providing 24-hour, 7-day per week day care facilities at the place of

8.6 (Cont'd)

employment and offer extended maternity leave to nurses who may wish to stay with their newborn during the first year following birth.

8.7 Recommendation # 7 - Scheduling

"Because nursing care of hospitalized patients is a 7-day, 24-hour responsibility, nursing practise in hospitals is notorious for unattractive work schedules" (Price, 1981:1138). In the last decade, hospitals throughout the United States and Canada have been experimenting with new, more attractive schedules for nurses.

In this province, many hospitals are offering 12-hour schedules to nurses as well as the traditional 8-hour shifts. A certain degree of satisfaction was noted with having these schedule options. the 12-hour shift has allowed nurses to have every other weekend off instead of the former one weekend in three. Furthermore, this new schedule of work, although somewhat more tiring, means less night shifts and longer periods of days off.

It was furthermore evident in focus groups and interviews that nurses are looking for more options and flexibility in scheduling. This was evidenced by their response to the Baylor Plan (Metcalf, 1982; Price, 1981) which allows for nurses to contract with their employer for a suitable schedule while meeting personal and financial needs. The element of control over such working conditions as scheduling is seen by nurses as an important satisfying factor (Weisman, 1982:27).

8.7 (Cont'd)

In order to allow for more flexibility and creativity in scheduling, it is recommended that:

1) That employers work collaboratively with staff nurses and their union representatives to develop and design creative staffing formulae which would meet standards of quality patient care while limiting rotation and that these be piloted to test their effectiveness. This, we believe would have a positive effect on staff-retention and recruitment and lower the incidence of unplanned leave.

2) That the responsibility for staffing/scheduling be that of the unit manager/head nurse. This strategy allows for more commitment of staff nurses and less rigidity in its implementation.

3) That utilization of part-time and casual employees be improved. Casual employees should be pre-assigned to a limited number of units and unit managers, receive an appropriate orientation based on needs and be involved in continuing education programs. Improved utilization of part-time employees should be studied so continuity and quality of care is not affected by its increased utilization.

4) That compensation be given for unused sick leave at the end of the year to lower the incidence of unplanned sick leave utilization.

8.8 Recommendation # 8 - Implementation

It is recommended:

That immediate steps be taken to demonstrate to nurses that the potential worklife problems that they experience are recognized and are being addressed.

Accordingly, it is proposed that the following specific activities be initiated.

1) Contract Negotiations

In the current negotiating process management and the union should address the issues of shift differentials, extended maternity leave, reimbursement for unused sick leave and a new bargaining unit for supervisors and head nurses.

2) Clinical Ladder Concept

Within one year the Nurses' Association of New Brunswick, Directors of Nursing, the New Brunswick Nurses Union, university schools of nursing, and staff nurses should develop guidelines for a clinical ladder concept for provincial hospitals. Implementation could then proceed through the next round of contract negotiations.

3) Post Basic Courses

The range of post-basic clinical courses offered should be expanded.

8.8 (Cont'd)

4) **Nurse Managers**

The roles and responsibilities of head nurses should be defined in updated job descriptions.

5) **Health Service Organizations**

Hospitals, primarily, and other delivery agencies, should establish internal committees to work toward the decentralization of nursing decision-making. These committees would involve:

- Directors of nursing, head nurses and staff nurses in developing guidelines for delegation including such functions as scheduling, the introduction of nursing models and alternative methods of patient care delivery, staff performance evaluation, staff recruitment and selection, and the like.
- Directors of nursing, head nurses, staff nurses and non-professional care staff preparing for the introduction of workload measurement systems and determining the appropriate division of labour.

In addition, committees involving nurses at all levels could be formed to develop the staff orientation process and a staff exchange program.

Hospital boards and administrators should immediately assess the extent to which senior nurse managers (director of nursing and assistant executive director of patient care) are involved in executive level functions within their organizations.

8.8 (Cont'd)

In all these endeavours progress and activity should be given high profile reporting in association and in-house newsletters.

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APPENDIX A
KEY INFORMANTS INTERVIEW GUIDE

KEY INFORMANTS
INTERVIEW GUIDE

Good Afternoon,

My name is ______________. I am a consultant working on a research project pertaining to the Quality of Worklife of Nurses in New Brunswick. (NAME OF REFERENT) of the (AGENCY WHERE REFERENT WORKS) suggest that I get in touch with you as he/she believes that; you may have helpful information to share with us on this project.

A survey of the nursing population of New Brunswick, as well as face-to-face interviews and focus groups are being used to obtain the data for the research. Twelve (12) variables are studied including workload, job related communication, accomplishment, recognition, utilization of knowledge and skills, decision-making, educational and promotional opportunities, scheduling, unit size and functions, salary and kinship. We are attempting to determine what areas bring the most and the least satisfaction as well as identifying potential solutions to improve the quality of worklife of nurses where problems are identified.

It is my understanding that you/your agency have/has looked at this issue and found ways to deal with the concerns. Would you mind sharing with me details regarding the approach you have taken.

PROBE:

a) Find out details of what the problem was. Did it pertain to workload, accomplishment, recognition, job-related communication, utilization of knowledge and skills, decision-making, educational and promotional opportunities, scheduling, unit size and functions, salary or kinship.

b) What were the signs of dissatisfaction experienced? (e.g. absenteeism, difficulties in retaining nurses, job mistakes, lack of enthusiasm, negativism or low morale).

c) Obtain as much detail as possible on the solution(s) utilized to resolve the problems.

d) What have been the results, what do nurses like and dislike about the approach? What does management like and dislike about the approach? Under what conditions would he/she recommend using a similar approach (e.g. could it apply to the NB situation?).

e) Do you have any documentation related to the information you first provided to me? If so, would you mind forwarding a copy?

Would you know of other programs implemented to improve the quality of worklife of nurses or anyone else who has done some work on the issue. Would you please provide me with more information in order for us to get in touch with these people or agency.

* Record information.

Is there anything else you may wish to comment on at this point?

* Accept final comments.

Thank you very much for your help. I have appreciated your input.

Goodbye.

APPENDIX B

QUESTIONNAIRE

Applied Management Consultants

NURSING QUALITY OF WORKLIFE

This questionnaire is designed to examine the experience of both practicing and non-practicing registered nurses in New Brunswick. It is asked that those respondents who are no longer practicing answer each question with regard to their last job in nursing, unless otherwise indicated.

SECTION I

For questions 1 - 22, please respond by circling the appropriate number.

1. What is your sex? 1) Female 2) Male

2. What is your age?
   1) 20-25
   2) 26-30
   3) 31-35
   4) 36-40
   5) 41-45
   6) 46-50
   7) 51-55
   8) 56 +

3. What is your marital status?
   1) Single
   2) Married
   3) Other (specify) ____________________

4. How many children do you have under 18 years of age?
   1) None
   2) One child
   3) Two children
   4) Three children
   5) More than three children

5. What is the age of your youngest child?
   1) No children
   2) Under 1 year of age
   3) Over 1 - under 5
   4) Over 5 - under 10
   5) Over 10 - under 15
   6) Over 15 - under 20
   7) Over 20 years

6. What is your first language?
   1) English
   2) French
   3) Other (specify) ____________________

7. Language used most at place of employment:

   1) English
   2) French
   3) Other (specify) ____________________

8. Are you employed as an RN at this time?

   1) Yes 2) No

9. If employed, who employs you at this time?

   1) General Hospital
   2) Rehab Centre
   3) Psychiatric Hospital
   4) Extra-Mural Hospital
   5) Other type of hospital
   6) Nursing Home
   7) Public Health Service
   8) Victorian Order of Nurses
   9) Mental Health Clinic
   10) Health Services Centre
   11) Physicians office/Family Practice Unit
   12) Occupational setting
   13) Educational Institution
   14) Self-Employment
   15) Association
   16) Government
   17) Addiction Centre
   18) Federal/Provincial Correctional Institution
   19) Armed Forces
   20) Private Duty Registry
   21) Other (specify) ____________________________

10. Do you work in:

   1) a large hospital? (more than ___ beds)
   2) a medium sized hospital? (___ beds)
   3) a small hospital (less than ___ beds)
   4) Not applicable

11. What is your highest degree?

   1) Certification/Diploma (specify) ____________________________
   2) Baccalaureate (specify) ____________________________________
   3) Masters Degree (specify) ___________________________________
   4) Doctorate (specify) ____
   5) Other Courses (specify) ____________________________________

   ____

12. Are you presently in training or upgrading?

1) Yes 2) No

13. In what area are you now employed:

General Patient Care

1) Medical/surgical
2) Maternal/newborn
3) Pediatrics
4) O.R.
5) Ambulatory care (DPD day surgery)
6) Geriatrics
7) Extended Care
8) Rehabilitative care
9) Chemical dependency
10) General practice/float
11) Community health

Special Care or Intensive Care

13) Coronary
14) Neonatal
15) Pediatric
16) Neuro
17) Burn
18) Medical
19) Surgical
20) Medical/surgical
21) E.R.
22) R.R.
23) Dialysis

Administration

24) Nursing Education Admin.
25) Nursing Service Admin.
26) Other admin.

Teaching

27) Student programs
28) Employee programs
29) Patient/client programs

Research

30) Full time
31) Part time

Other

32) Discharge Planning
33) Infection control
34) Independent practice
35) Other

14. Approximately how many years (total) have you worked as an RN?

1) Under 1 year
2) Over 1 - under 3
3) Over 3 - under 5
4) Over 5 - under 10
5) Over 10 - under 20
6) More than 20

15. What is your current position?

1) General duty/staff
2) Head nurse/senior clinical
3) Instructor/professor
4) Supervisor/coordinator

5) Clinical specialist
6) Associate/Assistant Director
7) Director
8) Assistant Administrator
9) Administrator/Chief Executive Officer
10) Consultant
11) Researcher
12) Other (specify) ____________________

16. What type of nursing is used on your unit or in your agency?

1) Team nursing
2) Primary nursing
3) Other (specify) ____________________
4) Not applicable

17. What is the average number of patients assigned to an RN on the day shift on your unit?

1) No more than 2 patients
2) From 3 to 5 patients
3) From 6 to 10 patients
4) From 11 to 15 patients
5) From 16 to 25 patients
6) More than 25 patients
7) Not applicable

18. If in community nursing, what is the average caseload for your agency?

1) Less than 25
2) 26 - 50
3) 51 - 75
4) 76 - 100
5) 100 +
6) Not applicable

19. Do you work rotation? 1) Yes 2) No

20. If not rotation, what shift do you most frequently work?

1) Day
2) Evening
3) Night
4) Not applicable

21. Approximately how many hours per week do you work?

    1) 35 - 40 hours in 5 days
    2) 35 - 40 hours in 4 days
    3) Two 12 hour weekend shifts
    4) 8 - 12 hours per week
    5) 12-20 hours per week
    6) Full time, plus an average of one or more overtime shifts per week
    7) Full time, plus occasional overtime of less than one shift per week (on average)

22. What is your approximate gross (before deductions) annual salary?

    1) Under $10,000 per year
    2) $10,000 to $15,999 per year
    3) $16,000 to $19,999 per year
    4) $20,000 to $22,999 per year
    5) $23,000 to $24,999 per year
    6) $25,000 to $27,999 per year
    7) $28,000 to $29,999 per year
    8) $30,000 to $32,999 per year
    9) $33,000 to $34,999 per year
    10) $35,000 to $39,999 per year
    11) $40,000 to $44,999 per year
    12) $45,000 to $49,999 per year
    13) $50,000 or more

23. How long have you been employed in your present facility?

    1) Under 1 year
    2) Over 1 - under 2
    3) Over 2 - under 3
    4) Over 3 - under 5
    5) Over 5 - under 7
    6) Over 7 - under 10
    7) Over 10 - under 15
    8) Over 15 - under 20
    9) 20 years or more

SECTION II

For the following items, please circle the number which best represents the degree to which the statement describes your situation.

Rating Scale: 1 = Never true
2 = Rarely true
3 = Sometimes true
4 = Often true
5 = Always true

I. ACCOMPLISHMENTS

1. I am satisfied with my opportunity to provide quality care. 1 2 3 4 5

2. At the end of my work day I usually feel as if I have done a good job. 1 2 3 4 5

3. Unit staff is permitted to implement innovative nursing care. 1 2 3 4 5

4. The community assesses our services positively. 1 2 3 4 5

5. Patient contact is sufficient. 1 2 3 4 5

II. RECOGNITION

6. My input regarding treatment planning is recognized by the attending physicians. 1 2 3 4 5

7. My co-workers on the nursing staff give me positive feedback about my work. 1 2 3 4 5

8. I feel that the Assistant Head Nurse and the Head Nurse acknowledge me for the work I do. 1 2 3 4 5

9. Disciplinary action is employed when my performance is inadequate. 1 2 3 4 5

10. My performance is regularly evaluated. 1 2 3 4 5

III. DECISION-MAKING

11. Too many decisions are made regarding patient care without my input. 1 2 3 4 5

12. Program changes occur without enough staff input. 1 2 3 4 5

13. When I provide care, I am able to make my own decisions about what interventions to use. 1 2 3 4 5

Rating Scale: 1 = Never true
2 = Rarely true
3 = Sometimes true
4 = Often true
5 = Always true

14. The staff criticizes me after I have made an independent decision. 1 2 3 4 5

15. I can bend the "rules" (policies and/or procedures) to meet special needs of patients if necessary. 1 2 3 4 5

IV. UTILIZATION OF KNOWLEDGE AND SKILLS

16. There are inadequate opportunities for me to share my knowledge with other nurses throughout the hospital/agency. 1 2 3 4 5

17. One thing I like about my work is that I have the opportunity to teach others. 1 2 3 4 5

18. None of the staff ask me about my continuing education experiences. 1 2 3 4 5

19. Clinical resources are available to assist me with patient care problems. 1 2 3 4 5

V. EDUCATIONAL OPPORTUNITY

20. I do not participate in as many conferences/educational events as I would like. 1 2 3 4 5

21. I am able to get the time off from work that I want to attend conferences and/or workshops related to my job. 1 2 3 4 5

22. I have increased my clinical experience by learning from my co-workers. 1 2 3 4 5

23. When new techniques/procedures are introduced, I am provided with training which increases my confidence in performance. 1 2 3 4 5

24. I am given full cooperation by my employer when attempting to obtain my Bachelor of Nursing Degree. 1 2 3 4 5

VI. PROMOTIONAL ADVANCEMENT

25. There are opportunities for advancements in my place of employment. 1 2 3 4 5

26. Education is directly related to opportunity for promotion in my place of employment. 1 2 3 4 5

27. Positions in desired specialty are available to me. 1 2 3 4 5

Rating Scale: 1 = Never true
2 = Rarely true
3 = Sometimes true
4 = Often true
5 = Always true

VII. PAY

28. Our fringe benefits are adequate. 1 2 3 4 5

29. My salary is representative of the level of responsibility my job entails. 1 2 3 4 5

VIII. WORKLOAD

30. The workload is not distributed fairly among nursing staff on my shift. 1 2 3 4 5

31. Other shifts leave work that should be done by them. 1 2 3 4 5

32. I am able to complete my work by the end of the shift. 1 2 3 4 5

33. Patients are assigned without any regard for the intensity of their care. 1 2 3 4 5

34. I feel satisfied with the amount of work shared with inter-disciplinary team members. 1 2 3 4 5

35. I am generally able to spend adequate time talking with patients. 1 2 3 4 5

36. I am frequently not able to take my full meal break. 1 2 3 4 5

IX. SCHEDULING

37. I am working the shift I prefer. 1 2 3 4 5

38. I do not like the system of permanent shifts. 1 2 3 4 5

39. I can schedule vacations when I want them. 1 2 3 4 5

40. Too often I am asked to double-shift. 1 2 3 4 5

41. Week-end coverage is not fairly distributed among the nursing staff. 1 2 3 4 5

42. Full time employment is available to me. 1 2 3 4 5

43. Part time employment is available to me. 1 2 3 4 5

Rating Scale: 1 = Never true
2 = Rarely true
3 = Sometimes true
4 = Often true
5 = Always true

X. UNIT SIZE AND FUNCTION

44. Supplies and equipment are adequate. 1 2 3 4 5

45. Physical plant is adequate. 1 2 3 4 5

46. Paperwork is limited. 1 2 3 4 5

47. Safe parking facilities are available at place of employment. 1 2 3 4 5

48. Pubic transportation to place of employment is available. 1 2 3 4 5

XI. JOB-RELATED COMMUNICATION

49. If personal matters are affecting my work, I feel I can go to the head nurse or assistant head nurse to talk about it. 1 2 3 4 5

50. I am satisfied with the amount of time the head nurse spends working with patients. 1 2 3 4 5

51. The attending physicians work closely with the nursing staff regarding treatment planning. 1 2 3 4 5

52. The head nurse does not keep me informed of decisions made at administrative meetings. 1 2 3 4 5

53. The administration is not supportive of the unit's philosophy of nursing care. 1 2 3 4 5

54. I feel satisfied with the amount of work shared with inter-disciplinary team members. 1 2 3 4 5

XII. KINSHIP

55. Travel time to and from employment is minimal. 1 2 3 4 5

56. My job does not interfere with my ability to fulfill my family responsibilities. 1 2 3 4 5

57. Child care facilities are available at place of employment. 1 2 3 4 5

INFORMATION SHEET

The quality of worklife among professional nurses in New Brunswick has, in recent years, illicited concern from numerous sectors of society; including the nursing profession, hospitals and other health care organizations, the Department of Health and Community Services; and the Government. In response to this concern, a committee has been formed to examine the current situation and has employed The DPA Group Inc. to conduct a study to provide the needed information.

The following questionnaire examines a number of factors which may be related to job satisfaction among nurses.

Confidentiality with regard to the information you provide is assured and your name will not be used in any part of the study.

Enclosed is a self-addressed envelope to enclose the completed questionnaire for return to us. In order that we may meet project deadlines, we would appreciate you mailing your completed questionnaire by June 2, 1988.

On behalf of The DPA Group Inc. and the Project Committee, we wish to express our thanks for your participation in this study. If you have any questions or concerns, please call the undersigned at 458-8370 between 8:30 a.m. and 4:30 p.m., Monday through Friday.

Yours truly,

Leanne E. Targett

Leanne E. Targett
Associate Consultant
The DPA Group Inc.

INTERVIEW GUIDE

I. ACCOMPLISHMENTS

1. Do you feel that nurses are satisfied with the quality of care which they are permitted to extend? Explain.

2. To what degree are Nurses permitted to implement innovative nursing care?

3. What is the community response to quality of patient care provided? Expand.

II. RECOGNITION

1. To what extent to nursing supervisors, co-workers, administrators and physicians recognize nurse's achievements and value their input?

2. In your experience, how regularly is nursing performance evaluated? What types of reward or discipline are employed in regard to such evaluation? When are those employed?

3. How are signs of dissatisfaction recognized and handled?

III. DECISION MAKING

1. What process is used with regard to patient care decisions?

2. To what degree are nurses able to have input into policy and procedures regarding the patient?

3. How do you view nurses who make independent decisions regarding patient care?

IV. UTILIZATION OF KNOWLEDGE AND SKILLS

1. Are nurses encouraged to share their skills and knowledge with one another? Is personal nursing expertise th~~r~~ought to be important enough that the transmittal of this is encouraged? In what way is this done?

V. EDUCATIONAL OPPORTUNITY

1. To what extent is educational supplementation supported among nurses? How does your facility accommodate nurses desiring to continue their training?

2. How is your facility maintaining or augmenting skills and knowledge as new procedure and technology are introduced?

3. Is the orientation process different for a new graduate or a nurse re-entering the profession after several years away as to a nurse who has been practicing for several years? How is it different?

VI. PROMOTIONAL ADVANCENT

1. Is promotional advancement available to many nurses? What kind of opportunities are open to general duty nurses? What warrants promotional opportunity? (What is required of the nurse seeking promotion?)

2. To what level are nurses prepared at the Bachelor level, the Master's level or the diploma level utilized differently?

3. Would you please describe the most utilized hiring practice? Are positions advertised for a specific unit? On what basis are nurses interviewed or selected?

VII. PAY

1. To what extent does the nurse's salary reflect the level of responsibility required by the job? Do you feel it is adequate?

2. What are the fringe benefits provided to nurses? How are these distributed? What criteria must be met for these to be obtained? Are they in your view adequate?

VIII. WORKLOAD

1. To what degree are non-nursing staff utilized? What functions do they perform? Are you comfortable with the utilization of non-nursing personal and the division of labour with nursing staff?

2. How is workload distributed among nurses? Is it evenly distributed? If not, what do you feel influences this imbalance?

3. Is the nursing manpower requirement adequate? If not where are problem areas? How is this problem experienced on a day-to-day basis at the nurses level and at the management level? (absenteism, lack of enthusiasm, job mistakes, cynism, unit closure, turnover, etc)

4. How often are patient-ratios changed? On what basis is this accomplished?

IV. SCHEDULING

1. To what extent are nurses involved in schedule development?

2. Are staffing requirements usually adequate to meet shift demands? Are nurses allowed to work part-time? If so to what extent?

3. What are the most often expressed complaints regarding scheduling? By nurses? By management?

X. UNIT SIZE AND FUNCTION

1. Do you feel that the equipment and technology used is up to date?

2. Is space well used/sufficient?

3. Do you feel there is too much paperwork done by nurses? If so please explain.

4. Is the facility/agency easily accessible ? (i.e. travel time limited, parking, on bus route, etc.)

XI. JOB RELATED COMMUNICATION

1. Describe the relationship of nurses with co-workers, physicians, nursing supervisors and head nurses, administrators and non-nursing personnel. Is there "open" communication between these sectors?

2. What type of system is established to facilitate communication? What channels are used to communicate information from one group to another?

3. Are there exit interviews with employees who leave the place of employment?

4. Is the fact that some Head Nurses are part of the Union at times problematic? If so, how?

XII. KINSHIP

1. To what extent does the facility/agency recognize the personal and familial needs of the nurses? How are these needs and responsiblities met?

APPENDIX C

QUESTIONNAIRE INFORMATION SHEET

INFORMATION SHEET

The quality of worklife among professional nurses in New Brunswick has, in recent years, illicited concern from numerous sectors of society; including the nursing profession, hospitals and other health care organizations, the Department of Health and Community Services; and the Government. In response to this concern, a committee has been formed to examine the current situation and has employed The DPA Group Inc. to conduct a study to provide the needed information.

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APPENDIX D

MODERATOR'S GUIDE

MODERATOR'S GUIDE

General Duty Nurses

INTRODUCTION

Hello, my name is _________. First of all, let me thank you for agreeing to participate in this discussion today. Let me just take a minute to explain what we are doing. This kind of group situation may seem a little unusual to you, but it is a great way for people like me to get to know how people like you think about someting. I work as a consultant and the company I represent has been asked by the New Brunswick Nursing Resources Advisory Committee to gather information on the quality of nursing worklife in New Brunswick.

The approach used for this research includes a Literature Review of current Canadian and U.S. journals and books permitting the identification of relevant research and tried solutions; interviews of several key informants who have been involved in researching the problem and in finding working solutions as well as regional face-to-face interviews. These are conducted in each health region of the province. Eight individuals per region - 56 in total - representing the union, the Association, nursing directors, middle nursing management and administration will also be interviewed.

There will also be interviews of representatives of the provincial Nurses' Union, NANB, the Hospital Association, the Nursing Homes Association, the Medical Society, the Department of Health and Community Services as well as the Board of Management. Furthermore, a mail survey of 10% of the nurses association members will be conducted as well as 13 focus groups such as this one.

The focus groups have been organized in each of the health regions to include randomly selected general duty nurses from all types of units (intensive care, pediatrics, psychiatry, operating rom, out-patient/emergency, medical/surgical, chronic and maternity) of regional, district and community hospitals; psychiatric hospitals, nursing homes and community services (public health, mental health, extra-mural, private physicians' offices, VON, corrections, industry, health services centres, and alcohol and drug treatment).

The goal of the research is for us to obtain a picture of what are the quality of worklife issues of concern to New Brunswick nurses and identify potential solutions to these concerns. We are meeting with groups like this throughout the Province of New Brunswick. It is an important project for the Province, and we really appreciate your help with it. Being Nurses yourselves, representing various work environments, we believe that you have very useful insights into this important issue.

Before we get started, there are a few things I would like you to know.

* First, you should make yourself at home. Help yourself to the drinks (etc.) whenever you like.

*The main idea in these kind of groups is for us to hear what is on your mind. There are no right or wrong answers. Say whatever you think. Your thoughts are just as important as those of the next person.

* I am going to be leading the conversation to some degree by raising a few questions, or maybe by asking you to tell me a bit more about something, but feel free to make any point that is on your mind. If you are thinking about something you think is interesting, feel free to say it. If someone else says something that you feel differently about, lets hear that also. We do not want to go away thinking you all feel a certain way if really only some of you do, and the rest of you have something quite different in mind.

* Now let me introduce (Name of recorder) to you. She is here to make some notes so that we are sure to remember the things you have to say. I usually get quite wrapped up in talking to people, but between the two of us we can usually make enough notes and remember what goes on.

* Just in case we can't, you have probably noticed that we have recording equipment here. This in our final back-up. If (name of recorder) and I am unclear about what you actually said, we get out the tape and go over it just to be sure.

* What you say here is confidential. We are going to report the overall ideas from the group, and not what any one person said. We will not ever connect a comment back to anyone's name. So you should feel that you can say whatever you wish.

TOPICS COVERED IN THE GUIDE

* Participants' profile

* Factors affecting job satisfaction

  - workload
  - job-related communication
  - accomplishment
  - recognition
  - utilization of knowledge and skills
  - decision-making
  - educational opportunities
  - promotional opportunities
  - scheduling
  - unit sizes and functions
  - salary, and
  - kinship.

* Solutions

Section I: Participants' profile

1. "Go around the table and ask everyone to introduce themselves (first name only), and indicate where they work, the kind of work they do, the position they hold, the shift they work on, whether they work part-time or full-time as well as some major non-work interests and responsibilities. Indicate that this information will give everyone a better idea of "who is who."

PROBE:

> Try to find out the nature of the post held, the employment status, whether they have academic or leisure activities during their off hours and whether they have parental responsibilities

Section II: Factors affecting job satisfaction

1. "Maybe the best place to start on the actual topic of quality of nursing worklife here in New Brunswick is to ask you how you feel about being a nurse in this province. Let's take an hypothetical situation where a friend of your young sister came to you one day and told you that she was thinking about becoming a nurse. Since you are a nurse with some experience, she thought

you could perhaps give her an idea of what it is really like to be a nurse and advise her as to whether she should enter a nursing school next fall. What would you say to her about your experience as a nurse?"

PROBE:

Workload

a) Find out what these nurses like/dislike about their work environment (adequate physical plant, overcrowding, up-to-date equipment); their caseload workload, the current staffing pattern (rotation, weekends, overtime, etc.); their benefits (salary, education, holidays, sick time, etc.).

Int. Relat
Comm.

b) What are the positive and negative features of their relationships at work (with patients/clients, collegues, with various assistants/technicians, with superiors, other professionals and with doctors). Do they feel valued in their place of employment. Are they asked to be involved in the various decisions made and do they feel they can share their knowledge and skills. What do they think of the waynurses are assessed/evaluated?

Accomp.
+ Recog.

c) Find out whether they find the job challenging and whether it matches what they had hoped it would be when they entered nursing school. Do they have opportunities to provide quality care? Do they obtain satisfaction from their patient contacts? What are their opportunities to get promoted?

Utilization

d) What are their thoughts on how well nursing schools prepare students for what is out there (2 yrs program and BSN). What do they perceive to be their employers' attitudes toward on the job training and continuing education? What are their view with regards to training and continuing education (e.g., should they decide what they need? Should they go on their own time? When shoudl the employer pay? The employee? What do they need?)

2. a. "More and more, we are hearing that nurses leave the profession to do something else. Do you believe this to be true in New Brunswick?"

b. "What are, in your view, the major causes of dissatisfaction of today's nurses? What is expected but not found? What do you think these people are seeking that they dont have in their present worklife? Why would some of you leave if you had the chance?"

PROBE:

Find out whether they actually know nurses who left the profession. Try to discover why they left. Be specific: eg. What kind of work? Better benefits (salary, vacation)? Better conditions of work (schedule,etc.)? More independence? Wanting more time with family? More support/appreciation; an opportunity too acquire more responsibitity without a BSN? The lack of professionalism or recognition as a professional.

c. "You may, at one time or another, have thought of leaving the nursing profession. How many of you ever did? What is it, do you think that makes nurses stay? What is it that you value in your work?"

PROBE:

Find out what are the incentives for nurses to remain in nursing. Be specific: eg. Challenge/benefits, satisfying contacts with patients/clients, with other professionals having similar goals/cause; salary; flexibility of schedule, status; etc.

3. "What would you say the impact of your position as a nurse is with regards to your life outside of work?"

PROBE:

Find out what is the impact of their work on their life with their spouses, their children, the other members of their family, their friends, their collegues, their spouses' collegues, their personal interests and activities (academic or leisure) and their health.

Section III: Future actions

1. "At this point, I would like to describe to you a few approaches that have been tried at various points in the past to resolve the nurses' sense of dissatisfaction related to their work and get you to react on the basis of how good you think these are. Let me know if you think they would work with the situations you encounter and the people you know, or if you think they might be OK with other people."

* Go through the programs outlined on the briefing notes. Read them over, one at a time and describe each of these approaches/solutions to the group. Ask for reactions to each of them.

PROBE:

What do people like and dislike about each approach? Can they see themselves ever going along with this type of approach? Would they help them be more satisfied in their worklife? Why? why not?

2. "Have you ever experienced or heard about ways to improve the quality of worklife for nurses that you would like to share with us? Let's hear about these"

PROBE:

Encourage people to be specific and to refer you to where these successful programs are implemented or where they got the information.

3. "Now as the last major question, let me ask you what you would really like to see happening in New Brunswick to improve the quality of life for nurses. From your personal point of view, what should be done?"

PROBE:

Encourage participants to be specific. Eg."Can you tell me a bit more? With this idea would you do _______, or would it be more like_________?

CLOSURE

"We have come to the end of our session for today. I have pretty well exhausted my list of questions and things I wanted to cover. Let me just give you one more chance to raise anything that might still be on your minds. Does anyone have any last comments they would like to make? Have we missed any important issues?"

* Accept final comments.

"Thank you very much for your help. I have enjoyed working with you, and a lot of really good things have come out. Thanks again!"

APPENDIX E

BRIEFING NOTES

BRIEFING NOTES

I INNOVATIVE STAFFING MEASURES

(i) Twinning (Job sharing)
(ii) The Baylor Plan

II SUPPORTIVE WORK ENVIRONMENT MEASURES

(i) Nurse to Nurse counsultation
(ii) Stess Workshops
(iii) Psychiatric Nurse Clinician
(iv) Debriefing Room
(v) Exchange program
(vi) New Graduates Program
(vii) Day Care Facility
(viii) Time Off
(ix) Feedback on performance

III PARTICIPATION IN THE DECISION MAKING PROCESS: COMMUNICATION

(i) Communication upward, downward, lateral
(ii) Employee management advisory committees
(iii) Hospital publications or letters to employees
(iv) Assertiveness Training Program

IV INDEPENDENT/EXPANDED FUNCTION OF THE NURSE

(i) Concept of Primary Nursing Care

V PROMOTIONAL OPPORTUNITY

(i) Levels of practice (clinical ladders) program
(ii) Selection process

VI BASIC TRAINING PROGRAM

BRIEFING NOTES - PROGRAM TYPES

I. INNOVATIVE STAFFING MEASURES:

There are a multitude of innovative staffing measures designed to improve nurses satisfaction and retention. There are also measures to attract nurses to work in health care facilities:

(i) TWINNING (JOB SHARING)

This is two permanent part time positions matched to fill an unfilled full time position. Two individuals share the responsibilities of the position while working permanently part-time with known rotations and benefits (as opposed to casual employement)

When a twinned position is filled, the nurses work out between themselves how they will cover work, how they will cover the position, allowing for a minimum of two shifts per week. In other words, if one of the "twins" wanted to work all afternoons, and the other all mornings, this is acceptable. Vacations are to be covered by the partner on a full time basis. If one twin is ill, she calls her partner first to see if she can fill in for her. If this cannot be arranged, the hospital takes over the staffing of the position.

(Ref: Dianne Doyle, Director of Patient Services; Mount St Joseph Hospital - Vancouver or Jean Stuart, Director of Nursing Services University of B.C. Health Sciences Centre Hospital)

(ii) THE BAYLOR PLAN:

The Baylor Plan is a plan where nurses contract with their employer to work on one of the following modes:

(a) Monday through Friday only during the day; these nurses work 7.5 hrs/day or 37.5 hrs/wk (75 hrs @ 2wks) for full pay and benefits

or

(b) Monday through Friday only to cover evenings and nights; three 12 hrs shifts one week and two 12 hrs shifts the other for a total of 57.5 hrs @ 2wks. They too receive full pay and benefits

or

(c) two 12 hrs shifts during the week end only (46 hrs @ 2wks) with full pay and benefits

The nurses contract with their employer for one of these shifts and keeps it for a certain period of time (ie 1 to 2 yrs). At the end of the contract, he/she can either renew the old contract or sign another depending on availability of shifts.

II. SUPPORTIVE WORK ENVIRONMENT MEASURES:

There are a number of measures which have been implemented which are designed to improve the work environment of nurses:

(i) NURSE TO NURSE CONSULTATION:

The program is run by a full time consultant with the help of registered nurses from a psychiatric unit. The services provided include consultation to nursing staff and consultation to nursing managers; support groups for experienced staff and new graduates; crisis intervention during times of severe work stress; interpersonal conflict mediation between nurses and physicians & nurse & nursing managers; stress management education. The nurse consultant holds bi-monthly support group meetings in various units. These groups allow nurses to vent their feelings of frustration with working in acute care bureaucracies; increase introspection and develop problem-solving skills & measures to resolve these frustrations; gain peer support for common pressures. The nurse consultant can also be utilized by a unit during high unit stress as well as by the hospital.

(ii) STRESS WORKSHOP:

A series of workshops given by an objective workshop leader can be provided to help nurses express concerns, anxieties, anger and pleasure with certain aspects of their work. As well, participants are provided with material which explains how to recognize job stress. It also teaches how to deal with it creatively through such activities as time management, relaxation techniques, diet and exercises.
Relaxation techniques and other stress reducing techniques such as mediation, visualizaitons and therapeutic touch are taught during these workshops.

(Burnaby Hospital, B.C.; Mary Preissl; Tel 980-9567)

(iii) PSYCHIATRIC NURSE CLINICIAN:

Some hospitals employ the services of a psychiatric nurse clinician who assess the psycho-social needs of "difficult" medical-surgical & critical care patients and promotes communication skills, improves staff interpersonal relationships and plans effective nursing measures. These objectives are achieved during the course of nursing care conferences where staff nurses and the Psychiatric Nurse clinician meet for an hour or so to share information. Problems are creatively solved and worked into the everday nursing plan. The psychiatric nurse clinician's primary aim is to teach nurses to deal efectively with the psycho-social aspects of patient care and with one another in the everyday working life of their own initiative. Team work can also be addressed by the clinicain.

(Pacific Presbyterian Hospital; San Francisco)

(iv) DEBRIEFING ROOM:

A room where nursing staff can vent their feelings concerning a difficult shift before going home is provided by the institution. This permits the nurse to "get things off her chest" and thus not take her anger and frustration home. The hospital provides for a place to sit down for a coffee and perhaps a small snack after a particular difficult day. The debriefing room is hosted by a nurse who belongs to a committee who wishes to work on this issue. The committee also organises monthly get togethers with perhaps wine and cheese for nursing personal & hospital administration.

(v) EXCHANGE PROGRAM:

This program aims at helping nurses maintain their positions on a unit they enjoy while giving them an opportunity to maintain knowledge and skills in other areas of practice as well as giving them an opportunity for taking a break from the routine of their work. The program is designed to coordinate interested nurses to float to other units when these become understaffed and when they are not too busy. Also within the program, a nurse can be part of an exchange program where he/she can apply to work on a different unit for a three to six month period. A nurse from that unit or another will replace that nurse on his/her unit for that same period of time

(vi) NEW GRADUATES PROGRAM:

New graduates could be in orientation throughout the hospital for a six-month period to acquire a better view of the work to be accomplished and be increasingly involved with making important decisions. They could be assigned a tutor on each of the units they work on during this rotation period as well as on the unit where they are to be permanently assigned. Furthermore, they are be provided with a support group which helps them go through the stress of facing the work reality of the nursing profession for the firest time.

(vii) DAY CARE FACILITY:

A five day per week day care facility is established and housed at the place of employment of the nurses. The Board of Direcors of the day care facility is named from the parents using the facility.

(viii) TIME OFF:

(a) Programs are instituted in some facilties where the nurse has the choice of taking either 3 weeks of paid vacation during the summer months (May to October) or four weeks during the winter months (October to May).

(b) The possibility of taking a sabbatical after 5 or 6 years of employment to do something else than nursing for one year is also adopted in some institutions. This time off without pay can be used to study, to travel, flounder or take a new hobby, to do community work or be with the family.

(c) Maternity leaves are extended for a one year period (without pay) after the usual maternity benefits have been utilized if the nurse does not wish to return to work right away after the birth of her child.

(ix) FEEDBACK ON PERFORMANCE:

Following a clear identification of what is expected of the nurse, his/her role, responsibilities and level of authority as well as what are expected standards of nursing care, the nurse receives regular feedback on her performance either through peer review or from her immediate supervisor. Areas which are well done are identified as well as areas which require improvement. Means to improve her practice (if required) are found. Performance evaluations are performed at least once a year.

III. PARTICIPATION IN THE DECISION MAKING PROCESS: COMMUNICATION

(i) COMMUNICATION UPWARD, DOWNWARD & LATERAL:

In this process, nurse managers meet to identify issues of importance to nursing staff and develops a written message about that issue for distribution. Each manager then conducts a group meeting with his/her subordinant supervisors. During thsoe meetings the message is discussed thoroughtly and the supervisors "role play" the discusions they will have with their staff when they distribute the information. Each supervisor is then expected to communicate the message either in group meetings or through informal conversation to all staff. Finally, short debriefing meetings are conducted by the managers with their supervisory groups to gauge employee reaction and identify new issues for discussion. These issues are taken to top management group meetings where the next message is prepared and discussed.

(ii) EMPLOYEE/MANAGEMENT ADVISORY COMMITTEES:

Employee/management advisory committees consisting of nursing staff representatives and supervisors selected for participation by nursing administration, can be useful vehicles for communicating employee concerns to management, carrying messages from management to staff, giving advice concerning needed or proposed changes such as means to reduce costs, or reviewing messages that administration is considering sending to staff.

(iii) HOSPITAL PUBLICATIONS OR LETTERS TO EMPLOYEES:

Through a hospital publication sent to employees, administration communicates to staff reasons behind administrative decisons as well as the plan of action it is considering. The administation demonstrates that they know at least in general terms, what conditions the floor are and that they are basing their decisions on the day to day realty of the units. Employee opinion surveys are conducted from time to time by the administration to obtain evidence of the employee's concerns prior to providing action or follow-through.

(iv) ASSERTIVENESS TRAINING PROGRAM:

A series of workshops using role play, paper and pencil excercises are provided to nurse managers and general duty nurses to help them act assertively when communicating their desires, needs as well as those of their patients/clients or urses they represent.

IV. INDEPENDENT/EXPANDED FUNCTION OF THE NURSE

(i) CONCEPT OF PRIMARY NURSING:

Primary nursing is a concept which places the accountability for practice in the hands of the nurse and where the decision making is decentralized.

Four (4) basic principles for accontability are identified for this model of nursing practice:

1. 24-hour responsibility and decision making for several patients by one nurse (she decides how care will be given to her group of patients, 24-hours a day, seven days a week)

2. Case method of assignment. Daily assignments for patient care are based on the care needs of the patients and the ability (nursing skills) of the staff available - not on the basis of room assignment

3. Direct communication between caregivers. There is a direct flow of communication between the nurse on one shift and the nurse on the next shift and between the nurse and other caregivers.

4. Role of the head nurse. The head nurse has a crucial role as a leader, communication facilitator, clinician and resource-person for the staff nurse as they plan and implement and evaluate the care of their patients. She is the quality control agent for the unit.

In some institutions (Sunnybrook Medical Centre, Toronto: Donna Crinklaw Wiancko) the nursing department encourages nursing staff on each unit to select a committee which represents all levels of nursing personnel. This elected body, known as the primary nursing committee, decides how primary nursing will be implemented and practiced on its unit. The unit clinical nurse specialist becomes a resource and facilitator for the committee as well as for the unit staff.

V. PROMOTIONAL OPPORTUNITIES

(i) LEVELS OF PRACTICE (CLINICAL LADDER) PROGRAM:

This program offers the nurse an opportunity for promotion through an established career ladder which takes into account the educational background of the nurse as well as his/her relevant experience.

(ii) SELECTION PROCESS:

The specialty-specific job description forms the basis of this model. The job description includes skills unique to the unit to which it applies. It includes tasks routinely conducted in the performance of the job as well as those more amorphous nursing skills essential to effective care. The level of required nursing preparation (Masters level, Baccalaureate program or two year program) is also indicated. The advertisement for an incumbent is also specialty-specific and interviews are conducted to select the best nurse who applied for that position.

VI. BASIC TRAINING PROGRAM

APPENDIX F

A SUBMISSION RESPECTING THE QUALITY OF THE WORKLIFE OF NURSES, THE NEW BRUNSWICK NURSES' UNION

A SUBMISSION RESPECTING
THE QUALITY OF THE WORKLIFE OF NURSES

PRESENTED BY:

THE NEW BRUNSWICK NURSES' UNION

TO

THE DPA GROUP INC.

JUNE 3, 1988

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    *COMPENSATION
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    *INCENTIVES
    *WORKING RELATIONSHIPS

VI. CONCLUSION

PURPOSE:

THE PURPOSE OF THE PRESENT DOCUMENT IS TO IDENTIFY WITHIN A BROAD FRAMEWORK THE FACTORS SPECIFIC TO NURSE EMPLOYMENT WHICH HAVE MADE THE WORKING LIFE OF NURSES' INTOLERABLE. SUCH INTOLERABILITY HAS CREATED THE SITUATION CONVENIENTLY DESCRIBED AS A "NURSING SHORTAGE".

IT IS THIS "SHORTAGE" AND THE COMPLEX DILEMMAS WHICH COMPOUND IT THAT WE PROPOSE TO EXPLORE IN THIS DOCUMENT.

THIS SUBMISSION, COUPLED WITH SUPPLEMENTARY DISCUSSION, WILL SERVE TO CAPSULATE THE PERSPECTIVES AND OBJECTIVES OF THE PROVINCE'S HANDS ON CARE NURSES.

ONE INTENT IS TO PROVIDE RECOMMENDATIONS ABOUT NOT ONLY WHAT MUST BE DONE, TO END A PERCEIVED SHORTAGE OF NURSES, BUT, TO END THE INTOLERABLE CONDITIONS UNDER WHICH MORE AND MORE NURSES ARE UNWILLING TO WORK.

INTRODUCTION:

AT THE MAY 5, 1988 ORIENTATION SESSION TO THE STUDY MANDATED BY THE NURSING RESOURCES ADVISORY COMMITTEE TO THE DPA GROUP INC., THE NEW BRUNSWICK NURSES' UNION (NBNU) WITH OTHER ORGANIZATIONS RELATED TO THE PROJECT, WERE ADVISED BY A DEPARTMENT OF HEALTH AND COMMUNITY SERVICES OFFICIAL OF THE TERMS OF REFERENCE FOR THE PROJECT. ITS' GOAL, AS DEFINED FOR THE NBNU, IS TO SERVE THE MINISTER OF HEALTH AND COMMUNITY SERVICES, IN AN ADVISORY CAPACITY, ON THE ISSUES CONFRONTING NURSES EMPLOYED IN THE VARIOUS SECTORS OF THE HEALTH SYSTEM AND, TO PROPOSE SOLUTIONS TO THESE ISSUES.

THE NBNU REPRESENTS 5,000 REGISTERED NURSES EMPLOYED BY THE HOSPITALS AND REGIONAL HEALTH CENTERS; THE HEALTH FACILITIES OF THE CIVIL SERVICE; AND 14 OF THE REGISTERED NURSING HOMES WITHIN THE PROVINCE. THE UNION ALSO REPRESENTS THE NURSING INSTRUCTORS AT THE DIPLOMA SCHOOLS OF NURSING AND THE REGISTERED NURSING ASSISTANTS AT THE MOUNT ST. JOSEPH EXTENDED CARE IN CHATHAM.

CONCERN FOR THE QUALITY OF WORKING LIVES OF OUR MEMBERS AND OUR BELIEF IN PROMOTING HIGH PROFESSIONAL STANDARDS AND QUALITY OF PATIENT CARE ARE FUNDAMENTAL TO OUR ORGANIZATION. THE CONSTITUTION AND BY-LAWS OF THE NBNU PROVIDES THE FOLLOWING:

> THE OBJECTIVE OF THE NBNU SHALL BE THE ADVANCEMENT OF THE SOCIAL, ECONOMIC AND GENERAL WELFARE OF ITS MEMBERS AND POTENTIAL MEMBERS INCLUDING PARTICULARLY THE FOLLOWING:
>
> (A) TO REGULATE THE EMPLOYMENT RELATIONS BETWEEN ITS MEMBERS AND THEIR EMPLOYERS INCLUDING PARTICULARLY, THE NEGOTIATION AND ENFORCEMENT OF COLLECTIVE AGREEMENTS BETWEEN THEM.
>
> (B) TO PROMOTE HIGH PROFESSIONAL STANDARDS OF PRACTICE AND APPROPRIATE WORKING CONDITIONS WITH A VIEW TO ACHIEVING THE BEST ATTAINABLE PATIENT CARE.
>
> (C) TO ORGANIZE AND RECRUIT NEW MEMBERS.
>
> (D) TO INFLUENCE LEGISLATION SO AS TO SAFEGUARD THE RIGHTS OF ITS MEMBERS AND THE PUBLIC AT LARGE.

(E) TO ENCOURAGE CO-OPERATION WITH RELATED FIELDS AND ORGANIZATIONS.

(F) TO ENCOURAGE THE EDUCATION OF ITS MEMBERS IN SUCH MANNER AS MAY BE DEEMED ADVISABLE TO ACHIEVE THESE OBJECTIVES.

THE NBNU SPEAKS FOR AND ON BEHALF OF ITS MEMBERSHIP.

ONE OF THE BENEFICIAL CONSEQUENCES OF NBNU'S CONTINUING WORK OF FULFILLING ITS MANDATE TO PROTECT AND ENHANCE THE QUALITY OF THE WORKING LIVES OF ITS MEMBERSHIP, IS THE EXPOSURE TO THE ATTITUDES AND PERCEPTIONS OF THE BEDSIDE NURSE. NO OTHER ORGANIZATION CAN TRUTHFULLY CLAIM TO UNDERSTAND AND REPRESENT THE STAFF NURSES FROM THIS PERSPECTIVE.

IN RECENT YEARS, NURSES IN THE PROVINCE HAVE INCREASINGLY BROUGHT THEIR CONCERNS REGARDING THE DETERIORATING QUALITY AND THEIR WORKLIFE AND THE IMPACT OF THIS ON PATIENT CARE TO NBNU THROUGH THE UNION'S "LET US HEAR FROM YOU" MEMBERSHIP QUESTIONNAIRE (1). THIS SURVEY COLLECTED KEY FINDINGS FROM NURSES WORKING IN HOSPITALS IN MAY OF THIS YEAR.

THE HANDS-ON-CARE NURSES WORKING IN THIS PROVINCE HAVE BEEN GROWING INCREASINGLY CONCERNED WITH THE LEVEL OF PATIENT CARE OFFERED TO THE CONSUMER OF THE HEALTH CARE SYSTEM. WE REALIZE THAT WE SHOULDER MUCH OF THE RESPONSIBILITY TO ENSURE THAT RESIDENTS OF THIS PROVINCE RECEIVE THE BEST POSSIBLE PATIENT CARE AVAILABLE ON A TWENTY-FOUR HOUR BASIS. THE MEMBERSHIP OF THE NBNU BELIEVES THAT THERE ARE SOME SERIOUS CONSIDERATIONS THAT MUST BE ADDRESSED IN THIS PROVINCE TO PRESERVE A LEVEL OF SERVICING THAT HAS COME TO BE EXPECTED AND DESIRED BY THIS PROVINCE'S HEALTH CONSUMER.

---

(1) 16 PAGE QUESTIONNAIRE SENT OUT IN APRIL 1988 TO 3700 NURSES EMPLOYED IN THE PROVINCE'S HOSPITALS

WHAT THEY ARE TELLING US IS THAT NURSES IN NEW BRUNSWICK ARE GENERALLY DISSATISFIED WITH THEIR PLIGHT. THEY HAVE BECOME INCREASINGLY DISCOURAGED WITH THE DETERIORATION OF THEIR WORKING CONDITIONS, THE INADEQUATE COMPENSATION FOR THE RESPONSIBILITY FACING THEM EACH SHIFT, AND, THE TOTAL LACK OF SUPPORT AND RESPECT THEIR EFFORTS RECEIVE FROM THEIR EMPLOYER AND OTHER PARTICIPANTS IN THE HEALTH CARE SYSTEM.

CONDESCENDING ATTITUDES TOWARDS STAFF NURSES ARE NOW BEING JUSTIFIABLY MET WITH RESENTMENT. THEY KNOW THAT THEY ARE A VITAL COMPONENT TO HEALTH CARE SERVICES IN THIS PROVINCE, YET THEIR INPUT IS WIDELY OVERLOOKED.

THE EXISTENCE OF THE CONDESCENDING ATTITUDE IS NOT SAVED FOR ANY ONE LEVEL OF THE HIERARCHY CONFRONTING THE STAFF NURSE, BUT IS EVIDENT AT ALL LEVELS AND MOST RECENTLY DEMONSTRATED BY LACK OF REPRESENTATION OF UNIONIZED NURSES ON THE NURSING RESOURCES ADVISORY COMMITTEE.

OTHER EXAMPLES INCLUDE:

- THE DETERIORATION OF CREDIBILITY OF THE NURSING DEPARTMENT DEMONSTRATED BY THE LACK OF WILL OF THE NURSING DEPARTMENT TO RELEASE NURSES FOR:
  (i) EDUCATION PURPOSES
  (ii) ATTENDANCE TO THE LICENSING BODIES ANNUAL MEETING
  (iii)OPPORTUNITY TO PARTICIPATE WITH THIS PROJECT
- THE FAILURE OF THE PROFESSIONAL PRACTICES COMMITTEE
- THE LACK OF SUPPORT FOR THE WORK SITUATION DOCUMENTATION SYSTEM.

WE BELIEVE THAT IT IS IMPERATIVE TO IDENTIFY THE FACTORS THAT HAVE CONTRIBUTED TO THE STRAINED STATUS OF THE NURSE SUPPLY BEFORE COMMITTING INEFFECTIVE EFFORT AND RESOURCES TO SOLVE THE PROBLEM. WITHOUT UNDERSTANDING WHY THE NURSING COMMUNITY HAS BEEN UNABLE TO PROVIDE AN ADEQUATE SUPPLY OF QUALIFIED, SPECIALIZED NURSES TO MEET THE PROVINCE'S NURSING NEEDS, A HASTILY PREPARED

REACTION WITHOUT EFFECTIVE STRATEGIC PLANNING WILL NOT PROVIDE THE LONG TERM SOLUTION.

DEFINITION OF NURSING SHORTAGE

NEW BRUNSWICK'S HEALTH CARE SYSTEM IS IN CRISIS.

IS THERE A NURSING SHORTAGE? OR, IS THE USE OF THIS PHRASE AN ATTEMPT TO GLOSS OVER THE "REAL" ISSUES OF WHY NURSES LEAVE NURSING, HAVE A HIGH TURNOVER RATE, OR WORK ONLY ON A PART-TIME OR CASUAL BASIS?

MANY NURSES ARE NOT WORKING FOR A VARIETY OF REASONS. HOWEVER, BY DEFINING THE PROBLEM AS A NURSING "SHORTAGE" WE MAY BE ATTEMPTING TO AVOID LOOKING AT THE REAL REASONS WHY THERE ARE NOT ENOUGH NURSES. THEN NOT ONLY ARE THE NURSING PROBLEMS BEING EVADED, BUT NURSES WILL BE VIEWED AS SCAPEGOATS.

WE HAVE LEARNT FROM OUR MEMBERS, THROUGH THE PREVIOUSLY DESCRIBED MEMBERSHIP QUESTIONNAIRE, THAT THE SITUATION IS FAR MORE COMPLEX THAN:

- A LACK OF REGISTERED NURSES AVAILABLE TO FILL VACANT POSITIONS, OR
- THAT NURSES HAVE LEFT FOR GREENER PASTURES, TO OTHER NURSING JOBS, MOVE TO OTHER JURISDICTIONS OR TO TAKE JOBS OUTSIDE OF NURSING ALTOGETHER.

HEALTH CARE FACILITIES ARE HAVING DIFFICULTIES FILLING VACANCIES AND IT IS CLEAR THAT SOME NURSES ARE LEAVING THE PROFESSION. NOTWITHSTANDING THIS, THE NUMBER OF NURSE POSITIONS HAS INCREASED OVER THE NUMBER OF YEARS AS REPRESENTED BY THE INCREASED MEMBERSHIP OF THE UNION.

IN 1985, THE UNION'S HOSPITAL BARGAINING UNIT REGISTERED 3,400 NURSES. TODAY, THAT FIGURE HAS SWELLED TO OVER 3,800 NURSES.

THIS IS THE ESSENTIAL CONTRADICTION OF THE DILEMMA FACING NEW BRUNSWICK'S HEALTH-CARE SYSTEM TODAY. THE PROBLEM IS NOT NECESSARILY THAT TOO FEW NURSES ARE AVAILABLE FOR VACANT POSITION - IT IS THAT TOO FEW NURSES ARE CHOOSING TO WORK IN THESE POSITIONS. WHEN ASKED ABOUT THEIR CONSIDERATION OF A CAREER OTHER THAN NURSING 64% (1212) STATED THAT THEY HAD CONSIDERED ALTERNATIVE CAREERS IN THE LAST TWO YEARS.

THE BOTTOM LINE IS THAT FOR MANY NURSES, THE PROFESSION HAS BECOME INTOLERAB~~LE. OPPORTUNITIES FOR CARING HAVE ALL BUT VANIS~~HED, AND MANY NURSES ARE REFUSING TO WORK UNDER INCREASINGLY UNBEARABLE CONDITIONS THAT DO NOT ALLOW THEM TO GIVE PATIENTS THE FULL AND PROPER CARE THEY NEED AND DESERVE. NURSING AS NURSES ONCE KNEW IT NO LONGER EXISTS.

NURSES' ISSUES

NURSES ARE REQUIRED TO ENDURE WORKING CONDITIONS THAT GREATLY REDUCE THE AMOUNT OF DIRECT QUALITY CARE THEY CAN GIVE TO THEIR PATIENTS. THESE CONDITIONS INCLUDE:

- TOO FEW SUPPORT STAFF - 99% (990) SAID THAT THEY HAVE WORKED ON A SHIFT WITHOUT ANOTHER RN OR ANOTHER STAFF MEMBER.
- EXCESSIVE PATIENT LOADS - 85.5% (1589) INDICATED THAT THE WORKLOAD IN THEIR AREA INCREASED IN THE PAST TWO YEARS.
- POOR WORK SCHEDULING - 80% (1394) INDICATED IMPROVED SCHEDULING AS A PRIORITY FOR IMPROVEMENTS IN WORKING CONDITIONS.

THESE FRUSTRATING CONDITIONS, COUPLED WITH OTHER WORKING-LIFE FRUSTRATIONS- LACK OF RECOGNITION, POOR EMPLOYER SUPPORT FOR EXTRA EDUCATION, LITTLE SAY IN HEALTH-CARE MANAGEMENT - HAVE CREATED A CRISIS BOTH FOR NEW BRUNSWICK NURSES AND

ITS HEALTH-CARE SYSTEM AS A WHOLE. COMMENTS FROM THE QUESTIONNAIRE ILLUSTRATE JUST HOW CRITICAL THE SITUATION IS:

- **"IF THINGS DON'T IMPROVE SOON, I DON'T KNOW HOW LONG I CAN LAST"**
- **"EVERY SHIFT, I WONDER WHAT AM I DOING THIS FOR"**
- **"THEY WANT US TO BE EDUCATED, BUT THEY WON'T EVEN LET US EXCHANGE SHIFTS TO WRITE OUR EXAMS".**

FOR NURSES, A COLLECTIVE BREAKING POINT HAS BEEN REACHED, AND INCREASING NUMBERS OF THEM HAVE BEEN PURSUING VARIOUS ALTERNATIVES. WHILE SOME NURSES HAVE LEFT NURSING ALTOGETHER, MOST HAVE CHOSEN TO REMAIN IN THE PROFESSION - AT LEAST FOR NOW. SOME HAVE LEFT HOSPITALS FOR OTHER NURSING POSITIONS IN THE HEALTH-CARE FIELD. MANY HAVE STAYED ON HOSPITAL STAFFS BUT ARE WORKING INSTEAD ON A PART-TIME OR CASUAL BASIS.

NURSES WHO MAKE WORK-PLACE ADJUSTMENTS WITHIN NURSING ARE OFTEN ABLE TO HAVE MORE CONTROL OVER THEIR WORKING LIVES, BUT THE UNDERLYING PROBLEMS REMAIN UNRESOLVED. THE RESULT FOR EMPLOYERS IS FEWER NURSES FOR FULL-TIME POSITIONS. THE HARSH REALITY FOR ALL IS REDUCED QUALITY OF PATIENT CARE.

THE NEW BRUNSWICK HEALTH SERVICE IS FORTUNATE TO HAVE A GROUP OF HIGHLY COMPASSIONATE AND PROFESSIONAL INDIVIDUALS WHO WANT TO HELP HEAL THE SICK, BUT WHO ARE OFTEN FRUSTRATED AT NOT BEING ALLOWED TO DO THEIR BEST WORK UNDER INCREASING UNBEARABLE EMPLOYMENT CONDITIONS. THE ESSENCE OF NURSING PRACTICE; COMMUNICATING WITH, CARING FOR, GIVING TO AND GENERALLY HELPING PEOPLE IS NOT BEING PROVIDED UNDER THE CURRENT WORKING CONDITIONS.

THROUGH MEETING WITH ITS MEMBERS AT ANNUAL, LOCAL AND LOCAL PRESIDENT MEETINGS, THE UNION HAS GROWN INCREASINGLY SENSITIVE TO ITS MEMBERSHIP'S BROAD RANGE OF DEEPLY FELT DISLIKES AND FRUSTRATIONS WHICH FAR OUTNUMBERS THE SPECIFICS LIKES THEY MAY HAVE HAD ABOUT THEIR JOBS.

PRIMARY CONCERNS ARE AS FOLLOWS:

POOR WORKING CONDITIONS AND RELATIONSHIPS

* NOT ENOUGH NURSES ARE HIRED FOR THE WORKLOAD. (WITH A VIEW THAT 85 PERCENT (1589 NURSES) OF NURSES WHO INDICATED THAT THEIR PERSONAL WORKLOAD HAD INCREASED OVER THE PAST 2 YEARS, 77 PERCENT (1412 NURSES) INDICATED THAT OVER THE SAME TWO YEAR PERIOD, THE STAFFING COMPLIMENT IN THEIR WORK AREA HAD DECREASED (29%) (533 NURSES) OR REMAINED THE SAME (48%) (879 NURSES).
* NURSES HAVE TOO MUCH STRESS PUT UPON THEM.
* NURSES OFTEN HAVE TO NON-NURSING TASKS LIKE CLERICAL WORK AND HOUSEKEEPING CHORES.
* NURSES DON'T HAVE TIME TO GIVE QUALITY CARE TO THEIR PATIENTS.
* WHEN PROBLEMS ARISE, A NURSE CAN BE LEFT RESPONSIBLE WITHOUT A SUPPORT SYSTEM.
* NURSES EXPERIENCE TOO MUCH BUREAUCRATIC/ADMINISTRATIVE INTERFERENCE IN THE JOB.
* STAFF NURSES DO NOT HAVE ENOUGH SAY IN THE WAY THE HEALTH-CARE SYSTEM IS RUN. (82 PERCENT (1388 NURSES) INDICATED IMPROVED CHANNELS OF COMMUNICATION WITHIN THE WORKPLACE THROUGH THE PROFESSIONAL PRACTICES COMMITTEE IS REQUIRED).
* FLOATING, WORKING IN AREAS WITHOUT ORIENTATION, OR WORKING WITH NURSES WITHOUT ORIENTATION HAS BECOME THE RULE, NOT THE EXCEPTION (83 PERCENT (1393 NURSES) IDENTIFIED IMPROVED ORIENTATION AS PRIORITY IN THEIR WORKLIFE). THERE ARE VERY FEW AREAS IN AN ACUTE CARE INSTITUTION WHERE A NURSE WITH NO PRIOR EXPERIENCE IN THE AREA CAN SAFELY AND KNOWLEDGEABLY TRANSFER. YET IT HAPPENS EVERY SHIFT IN EVERY FACULTY.

- NURSING ADMINISTRATORS ARE OFTEN INATTENTIVE TO NURSES' NEEDS FOR EDUCATION.

INADEQUATE COMPENSATION

- NURSES ARE NOT COMPENSATED ADEQUATELY FOR A JOB AS RESPONSIBLE AS NURSING. 173 NURSES IDENTIFIED THAT THEY HAVE BEEN ON WORKER'S COMPENSATION IN THE LAST TWO YEARS, COUPLED WITH 52 NURSES ON LONG TERM DISABILITY.
- NURSES' SALARIES ARE RELATIVELY POOR COMPARED TO OTHER PROFESSIONS. (TEACHERS, DOCTORS, ENGINEERS).
- EXCELLENCE IS NOT REWARDED FINANCIALLY.
- LONG-TERM SERVICE IS NOT REWARDED, SINCE THE SALARY GRID STOPS AFTER SIX YEARS SERVICE (77 PERCENT (1466 NURSES) OF WORKING NURSES INDICATED THAT THEY ARE NOW AT THIS LEVEL).

LACK OF INCENTIVES

- NURSES RECEIVE LITTLE OR NO RECOGNITION FOR THEIR LEVELS OF SKILL OR EXPERIENCE.
- NURSES RECEIVE NO INCENTIVE TO UPGRADE THEMSELVES WITH NO ENCOURAGEMENT TO EXPRESS PROFESSIONAL OPINIONS.
- TOO FEW OPPORTUNITIES FOR ADVANCEMENT.
- NURSES' PENSIONS AND OTHER BENEFITS ARE INADEQUATE. (86 PERCENT (1446 NURSES) STATED THAT IMPROVEMENTS IN THE CURRENT NURSES PENSION PLANS ARE REQUIRED).

THIS IS AN ASTONISHING RANGE OF FRUSTRATIONS WITH ONE'S WORKING LIFE. TAKEN TOGETHER, THE MANY UNSATISFACTORY WORKING CONDITIONS OF NURSING THAT EXISTS IN NEW BRUNSWICK TODAY FORM AN ALMOST INSURMOUNTABLE BARRIER TO THE PROVISION OF

QUALITY NURSING CARE TO PATIENTS IN THIS PROVINCE. BY SPEAKING OUT ABOUT THESE CONDITIONS, NURSES ARE MAKING A COLLECTIVE PLEA FOR HELP, BOTH TO SAVE THEIR PROFESSION AND TO PREVENT FURTHER SERIOUS DETERIORATION OF LONG-HELD, HIGH-QUALITY STANDARDS OF PATIENT CARE.

THE COMING CRISIS

NURSES ARE VOICING THEIR CONCERNS LOUDLY AND CLEARLY AND THE NURSES HAVE SET THE FOCUS FOR THE UPCOMING NEGOTIATIONS: IMPROVED WORKING CONDITIONS.

A CRISIS OF MONUMENTAL PROPORTIONS LOOMS AHEAD OF OUR HEALTH-CARE SYSTEM UNLESS CORRECTIVE ACTIONS ARE TAKEN NOW TO STEM A POTENTIALLY SERIOUS LOSS OF NURSES FROM THE SYSTEM. OTHERWISE, WHAT IS NOW ONLY A "PSEUDO" SHORTAGE (*1) WILL BECOME A REAL NURSING SHORTAGE WITH STAGGERING IMPLICATIONS FOR BOTH THE FUTURE QUALITY OF PATIENT CARE AND THE GENERAL FUNCTION OF THE HEALTH CARE SYSTEM AS A WHOLE.

RECOMMENDATIONS FOR CHANGE

SOLUTIONS TO THE PROBLEM OF DECLINING PATIENT CARE, WHICH IS THE FUNDAMENTAL ISSUE, WILL REQUIRE THE PROVINCIAL GOVERNMENT AND HEALTH CARE ADMINISTRATORS ACROSS THE PROVINCE TO CHANGE THEIR ATTITUDES AND POLICIES REGARDING REGISTERED NURSES, THE FRONTLINE CAREGIVERS OF OUR HEALTH-CARE SYSTEM. SUCH CHANGES, HOWEVER, WILL REQUIRE MAJOR STRUCTURAL ADJUSTMENTS IF THE TRUE POTENTIAL OF NURSES IS TO BE REALIZED AND THE QUALITY OF PATIENT CARE IMPROVED. APPROACHES TO THE PROBLEMS OF THE SHORTAGE AND NURSE DISSATISFACTION MAY BE MANY. THERE IS NO

***1 PSEUDO SHORTAGE - REFERRED TO IN THE 1981 MANPOWER REPORT P15. GENERALLY THEN, THE OVERALL GENERAL SHORTAGE IS IN FACT A PSEUDO SHORTAGE AND THE PROBLEM IS NOT SO MUCH A LACK OF REGISTERED NURSES BUT RATHER AN INABILITY OF THE HOSPITAL TO RETAIN THEM FOR LONGER PERIODS OF TIME.**

SINGLE ANSWER, BUT THE UNION OF NURSES BELIEVES THAT THE PROBLEMS WITHIN THE SYSTEM ITSELF MUST BE SOLVED TO IMPROVE WORKING CONDITIONS UNDER WHICH MORE AND MORE NURSES WILL BE WILLING TO WORK. THE SOLUTION TO CHRONIC STAFFING SITUATIONS THAT CONFRONT THE EMPLOYER OF NURSES IN THE PROVINCE CAN BE FOUND IN IMPROVEMENTS IN THE AREAS OF:

RECRUITMENT OF INDIVIDUALS TO NURSING;

RETENTION OF OUR EXPERIENCED NURSES; AND

RECOGNITION OF THE RESPONSIBILITIES CARRIED OUT BY NURSES.

FOUR MAJOR ISSUES THEN, REQUIRE ATTENTION:

A. **COMPENSATION,**

B. **SUPPORT STAFF,**

C. **INCENTIVES, AND**

D. **WORKING RELATIONSHIPS.**

A. COMPENSATION

SALARY LEVELS AND STRUCTURES MUST BE IMPROVED TO RECOGNIZE THE FULL VALUE AND WORTH OF NURSES SO AS TO KEEP EXISTING NURSES AND TO ATTRACT NEW PEOPLE TO THE PROFESSION. THE FOLLOWING MEASURES ARE REQUIRED:

- **HIGHLY EXPERIENCED NURSES SHOULD BE PAID AT SUBSTANTIALLY HIGHER RATES THAN LESS EXPERIENCED NURSES IN RECOGNITION OF THEIR ADVANCED SKILLS.**
- **NURSES WITH ADVANCED NURSING EDUCATION SHOULD BE REWARDED WITH AN INCREASE IN SALARY.**
- **SUBSTANTIAL DIFFERENCES IN WAGES FOR EVENING, NIGHT AND WEEKEND WORK SHOULD BE PROVIDED TO HELP ENSURE SUFFICIENT STAFF FOR THESE PERIODS. ROTATING SHIFTS SHOULD NO LONGER BE CONSIDERED A REQUIREMENT OF EMPLOYMENT BUT INSTEAD REPLACED WITH AN OPTION OF PERMANENT SHIFTS.**

- SCHEDULING MUST BE MADE MORE FLEXIBLE. (I.E. MIX OF 12 AND 8 HOUR SHIFTS).
- A COMPREHENSIVE AND DIFFERENTIATED WAGE STRUCTURE THAT RECOGNIZES WORK EXPERIENCE, SKILLS AND KNOWLEDGE GAINED THROUGH EXTRA EDUCATION, AND A READINESS TO WORK AWKWARD SHIFTS WOULD DO MUCH TO RELIEVE MANY OF THE STAFF PROBLEMS HEALTH-CARE FACILITIES ARE CURRENTLY EXPERIENCING.
- UPGRADING OF THE CASUAL NURSE EMPLOYEE TO A CATEGORY OF EMPLOYMENT THAT EXCHANGES A MUTUAL COMMITTMENT BETWEEN THE EMPLOYER AND THE INDIVIDUAL COULD ALSO ALLEVIATE THE STAFFING STRAINS.

B. SUPPORT STAFF

NURSING SUPPORT STAFF MUST BE INCREASED TO ALLOW NURSES TO DO WHAT THEY DO BEST - CARE FOR THEIR PATIENTS. BETTER-PAID NURSES COMBINED WITH ADEQUATE SUPPORT STAFF WOULD YIELD BETTER PATIENT CARE WITHOUT SUBSTANTIAL INCREASES IN OPERATING COSTS.

C. INCENTIVES

COMPARED TO OTHER PROFESSIONS, SUCH AS TEACHING, NURSING LAGS FAR BEHIND IN PROVIDING INCENTIVES FOR LEARNING AND DEVELOPING SKILLS, AND STAYING WITHIN THE PROFESSION.

- PROGRAMS ENCOMPASSING TUITION SUPPORT AND PAID SABBATICALS WOULD DO MUCH TO ENCOURAGE NURSES TO REMAIN WITH A GIVEN POSITION LONGER, THEREBY REDUCING STAFF TURN-OVER.
- IMPROVED PENSION ARRANGEMENTS WOULD MAKE NURSING A BETTER CAREER TO CONSIDER FOR THE LONG TERM.
- DEVELOP CLINICAL LADDERS TO REWARD WITH BOTH MONEY AND RECOGNITION THOSE NURSES WHO WORK IN THE CLINICAL AREA.
- INADEQUATE FINANCIAL ASSISTANCE FOR EDUCATION,

85 PERCENT OF NURSES RESPONDING TO THE AFOREMENTIONED QUESTIONNAIRE INDICATED THAT THEY WOULD REQUIRE FUNDING TO PURSUE EDUCATIONAL UPGRADING.

EXPERIENCE WITH THE EDUCATION LEAVE COMMITTEES, ESTABLISHED IN OUR HOSPITAL AND CIVIL SERVICES COLLECTIVE AGREEMENTS, IDENTIFIES VERY CLEARLY A SENSE OF NEAR DESPERATION TO OBTAIN THE ESCALATED EDUCATIONAL REQUIREMENT. CONTRIBUTING TO THIS ANXIETY IS:

* INACCESSIBILITY OF DEGREE COURSES IN MOST AREAS OF THE PROVINCE
* A LACK OF CO-OPERATION FROM MANAGERS OF NURSES TO ACCOMMODATE REQUIRED SCHEDULING CHANGES TO AFFORD THE ATTENDANCE IN CLASS AND WRITING OF EXAMINATIONS
* THE INADEQUATE NATURE OF SCHEDULING OF COURSES BY THE UNIVERSITIES.
* PROVIDE CONSCIOUSNESS-RAISING OR STRESS-MANAGEMENT GROUPS UTILIZING PEOPLE OTHER THAN DIRECT SUPERVISORS SO THAT INTERACTION IS FACILITATED. THE GOAL, MORE THAN MERE CATHARSIS, CAN INCLUDE PERSONAL AND PROFESSIONAL EDUCATION, CONFLICT RESOLVING, AND PROBLEM SOLVING.

D. WORKING RELATIONSHIPS

MUCH OF THE DISSATISFACTION NURSES HAVE WITH THEIR WORKING LIVES COMES FROM HAVING INSUFFICIENT INPUT AS TO HOW HEALTH-CARE SERVICES ARE ORGANIZED AND DELIVERED. INCREASED PARTICIPATION IN THE DECISION-MAKING PROCESS ON AN EQUAL BASIS WITH OTHER HEALTH-CARE PROFESSIONALS AND ADMINISTRATORS WOULD ALLEVIATE THE SENSE OF POWERLESSNESS AND THE LACK OF RECOGNITION NURSES MUST NOW ENDURE. THE HEALTH-CARE SYSTEM OVERALL WOULD BE GREATLY BENEFITED; PATIENTS CARE WOULD BE DRAMATICALLY IMPROVED.

ENCOURAGE NURSING'S AUTONOMY. THIS MEANS NURSING IS RESPONSIBLE FOR ITS OWN PRACTICE AND HAS THE AUTHORITY TO MANAGE THAT PRACTICE:

- * EQUALIZE NURSING AND MEDICINE FORMALLY IN THE HOSPITAL HIERARCHY. IF MEDICINE REPORTS DIRECTLY TO THE HOSPITAL BOARD OF DIRECTORS, THEN NURSING SHOULD AS WELL. NURSES SHOULD BE VOTING MEMBERS ON ALL HOSPITAL COMMITTEES.
- * ENCOURAGE A CLIMATE IN WHICH ALL NURSES HAVE INPUT INTO PRACTICE AND POLICY ISSUES.

THESE RECOMMENDATIONS FOR CHANGE ARE NOT NEW; THEY HAVE BEEN ADVOCATED BOTH IN THIS COUNTRY AND ELSEWHERE FOR SEVERAL YEARS. CRUCIAL TODAY, HOWEVER, IS THE SERIOUSNESS OF THE PROBLEMS BESETTING THE HEALTH-CARE SYSTEM AS BEST EXEMPLIFIED BY THE DECLINING QUALITY OF PATIENT CARE. THE STAFFING PROBLEMS NOW BEING CALLED A NURSING SHORTAGE CAN ONLY BE RECTIFIED BY RESTRUCTURING THE HEALTH-CARE SYSTEM SO AS TO MAKE OPTIMUM USE OF THE SPECIAL EXPERTISE FOR QUALITY PATIENT CARE THAT ONLY NURSES POSSESS.

NURSES ARE READY TO HELP SOLVE THE PATIENT-CARE CRISIS FACING NEW BRUNSWICK'S HEALTH-CARE SYSTEM TODAY. BUT, FUNDAMENTAL CHANGES IN THE SYSTEM MUST BE MADE TO ALLOW THEM TO FUNCTION AS THE NURSES THEY WANTED, AND WERE EDUCATED, TO BE. RETURN THE NURSING PROFESSION TO NURSES, AND THEY WILL RETURN TO THE PROFESSION.

THE ROLE OF THE GOVERNMENT

GOVERNMENT AS THE FUNDING AGENT OF THE HEALTH FACILITIES AND AGENCIES, IN THIS PROVINCE EITHER INFLUENCES OR PLAYS A MAJOR ROLE IN DECISIONS REGARDING THE OPERATION OF THE SERVICES. NBNU BELIEVES THAT THERE MUST BE PUBLIC ACCOUNTABILITY BY THE HEALTH CARE SYSTEM, NOT ONLY ON THE PART OF THE REGISTERED NURSE, BUT ALSO ON THE PART OF THE HEALTH CARE INSTITUTION THROUGH ITS BOARD OF DIRECTORS AND ULTIMATELY THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES.

CONCLUSION

THE NBNU, IN RECOGNIZING THE GAMBIT OF SUCH AN AMBITIOUS UNDERTAKING, PARTICULARLY IN SUCH A SHORT PERIOD OF TIME, SUPPORTS THE DEPARTMENTAL ENDEAVOUR TO ADDRESS THE CONCERNS OF THE NURSE'S WORKPLACE. OUE ENDORSEMENT OF THIS PROJECT, HOWEVER, IS WITHHELD. OUR OPERATIONAL CONTRIBUTION IS SIGNIFICANT, YET, DUE TO THE STRATEGIC NEGLECT OF THOSE ADVISING THE MINISTER, OUR REPRESENTATION IS NOT PRESENT ON THE NURSING RESOURCES ADVISORY COMMITTEE.

WITHOUT INCLUDING THE NURSES' UNION IN FUTURE HEALTH PLANNING IS SHORT-SIGHTED AND IGNORES THE PROFESSIONALISM OF NURSES.

THE UNION MEMBERS FULFILL THEIR NURSING RESPONSIBILITIES ACCORDING TO A CREED THE CANADIAN NURSES ASSOCIATION CODE OF ETHICS WHICH STATES UNDER THE SOCIAL CONTEXT OF NURSING:

> XI. CONDITIONS OF EMPLOYMENT SHOULD CONTRIBUTE TO CLIENT CARE AND TO THE PROFESSIONAL SATISFACTION OF NURSES. NURSES ARE OBLIGED TO WORK TOWARDS SECURITY AND MAINTAINING CONDITIONS OF EMPLOYMENT THAT SATISFY THESE CONNECTED GOALS.

THE UNION WILL AWAIT THE MINISTER'S RESPONSE TO THE FINAL REPORT OF THIS PROJECT WITH ANTICIPATION. OF PARTICULAR INTEREST IS WHETHER THE REPORT WILL EXPERIENCE THE SAME FATE OF THE 1981 REPORT OF MANPOWER CONSULTATIVE COMMITTEE OF NURSING SHORTAGE.

FOR THE NURSING SERVICE TO CONTINUE, CHANGES MUST BE MADE. THE FUTURE WILL UNFOLD. THE CHOICE, THE DEPARTMENT OF HEALTH HAS, IS TO ANTICIPATE IT AND PREPARE OR IGNORE IT AND REACT TO ITS DEMANDS AFTER THE FACT. EITHER HAS COSTS AND CONSEQUENCES. THEREFORE, THE CHOICE MUST BE MADE HONESTLY AND WITH SERIOUS DELIBERATION AND, WITH STRAIGHT FORWARD HONESTY.

APPENDIX G

NURSES ASSOCIATION OF NEW BRUNSWICK PRESENTATION ON CONCERNS OF NURSES IN NEW BRUNSWICK

NURSES ASSOCIATION OF NEW BRUNSWICK

PRESENTATION

ON CONCERNS OF NURSES IN NEW BRUNSWICK

TO

THE NURSING HUMAN RESOURCES ADVISORY COMMITTEE

June 6, 1988

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Appendix 1 - Report of the Special Committee on Entry to Practice

Acknowledgements

NANB gratefully acknowledges the information that was generously shared with us by the Alberta Association of Registered Nurses. The format and some areas of content from their document entitled "Brief on Concerns of Registered Nurses Employed in Alberta Hospitals and Nursing Homes" March, 1988 have been adapted and included in this presentation.

Outline of a Presentation to the Nursing Human Resources Advisory Committee

By legislation, the Nurses Association of New Brunswick is responsible for developing, establishing, maintaining and administering standards for its members (NANB, Nurses Act, 1984). Recent advances have been made in developing of standards for orientation programs, workload measurement and medical-nursing procedures to name but a few. However, these advances in the development of standards have not been matched with advancements in their implementation. The lack of moral and fiscal support from government and health care institutions has impeded NANB's ability to fulfill its responsibility to provide for the welfare of its 8000 members as well as the public.

This presentation outlines some of the problems associated with the worklife of nurses in New Brunswick that must be addressed to ensure that there will be sufficient numbers of adequately prepared nurses to meet the health care needs of society now and in the future. The particular concerns of New Brunswick nurses expressed in this presentation are grouped into 7 major areas. These are: 1) roles and functions of nurses; 2) the public's perception of the role of the nurse; 3) the medical profession's perception of the role of the nurse; 4) the organization of nursing service within the health care system; 5) preparation for professional nursing; 6) recruitment and retention; and 7) long range fiscal planning.

Nurses are neither handmaidens nor servants. Indeed nurses have both **independent** and **interdependent** roles in nursing practice, education, administration, and research. The view of the nurse as an individual who takes orders and performs tasks is inconsistent with the knowledge and judgement of the skilled practitioner who assesses clients' needs, plans, provides, supervises, coordinates and evaluates 24 hour care to clients and families. Failure to recognize and use the knowledge and skills of nurses reduces the quality of care. Personal satisfaction for nurses results when structures are in place which support the professional practice of nursing. The worklife of nurses in New Brunswick does not often provide such supportive structures. The nurses' ability to provide professional care is compromised and the result is personal stress, frustration and disillusionment.

Factors which affect the delivery of nursing care include the organizational structure, staffing, and modes of nursing care delivery. Efforts have been made to flatten the organizational structure in some institutions to provide for participative management, however, the traditional tall organizational structure with its hierarchical and bureaucratic arrangement of nursing service remains predominant. While this structure promotes formal downward communication, it also limits the opportunity for nursing input, negates the professional autonomy of nurses, decreases opportunities for nursing representation at decision-making levels, reinforces the traditional image of nurses as low-level, low paid employees, and contributes to under-utilization of nursing skills and over-supervision of nurses. In addition, there are unrealistic expectations that nurses will assume duties in any area of the hospital, including non-nursing functions.

Nursing budgets are the primary target for cutbacks. Key factors which should determine nurse staffing include client acuity, availability and educational preparation of staff, the mode of delivery of nursing care (functional, team, primary), and levels of supervision. Budget imperatives, however, take precedence over key factors in making staffing decisions.

Staff nurses seldom experience an opportunity to participate in management decisions. Inadequate orientation, lack of continuing inservice, perceived need for more education, and failure to share resources (such as clinical expertise) result in lack of job satisfaction. Sicker clients are being given care by fewer nurses. This further increases the stress levels of management and staff nurses.

In the complex field of health care, nurses require a broad education based on the physical and social sciences, and grounded in the theory of their discipline. There is a constant pressure to update their basic education to keep pace with research findings, new theories, and technology. In a profession largely comprised of women, there is a constant movement in and out of the workforce. Re-entry requires additional learning and may occur several times during a nurse's work life. As the discipline of nursing evolves, nursing practice becomes more specialized and requires advanced education.

Nurses avidly seek educational opportunities for both clinical and functional areas of practice. The nurse embarking on an educational program usually does so in the hope of improving performance, personal satisfaction, gaining recognition by the employer, and career advancement. Nurses do not enjoy the same recognition for education as teachers do in this province.

The full potential of the nursing profession will not be realized until nurses themselves have control over it, until the physician-centered pattern of medical care is replaced by a community based health team approach and, perhaps most important, until governments recognize the crucial role of nursing personnel within the health care system.

NANB's concerns about funding are twofold. First, legislators, must reconsider funding priorities in the health care system particularly the inordinate capital expenditures related to building projects. Second, global budgets are not always appropriately distributed within health care agencies. Hospital and nursing home boards must re-examine the criteria used to determine the allocation of funds to nursing departments to ensure adequate resources.

The recruitment and retention situation in New Brunswick has reached a crisis state. We commend the Nursing Human Resources Advisory Committee for its request for NANB's obervations of the critical concerns of nurses working in the system. We strongly advise the Committee to be equally vigilant in the formulation of recommendations for solutions and prompt action is anticipated on those recommendations by the Government of New Brunwick.

Summary of Recommendations to the Nursing Human Resources Advisory Committee

1. That the province of New Brunswick encourage federal and provincial manpower planning for the '80's and '90's that reflects the changing role of nursing in health care.
2. That greater prominence be given to the nurses' role in health screening, assessment, health education and coordination of services particularly in the community setting.
3. That the Department of Health and Community Services be restructured to create a workplace that encourages nurses to fulfill present and future nursing responsibilities as identified by the nurses of this province.
4. That the Province of New Brunswick support the Canada Health Act to allow the emergence of a health insurance program that would stimulate the development of health promotion and disease prevention programs, permit the introduction of new entry points to the health care system, and promote the appropriate utilization of qualified health personnel.
5. That a joint practice committee representing physicians and nurses be established in each agency to promote dialogue on professional issues.
6. That hospital administration, boards and physicians be provided with an orientation concerning the professional role of nursing in health care.

7. That the senior nursing person (however designated) be made directly accountable to the chief executive officer and that provision be made for her direct communication with the Board of Trustees of the health care agencies.

8. That the senior nursing person be provided with the authority as well as the responsibility to determine how costs for the nursing department will be defined, controlled, accounted and monitored.

9. That regional senior nurse managers be appointed, with management line authority, to oversee and evaluate nursing services in the community setting.

10. That organizational structures in hospitals, nursing homes and other health care agencies be decentralized in order to promote the autonomy of professional nursing practice and reduce the levels of supervisory personnel.

11. That participative management be explored as a feasible method of decision-making.

12. That crisis funding for development and provision of management courses be available over the next five years to all senior nurse managers and administrators in health care agencies who are not currently prepared.

13. That appropriate funding be provided to establish adequate periods for orientation of all nursing staff (full, part-time, and casual) as outlined in the NANB Guidelines for Orientation.)

14. That all agencies establish orientation programs for nurses related specifically to equipment and technology prior to work assignments.

15. That alternate, more flexible patterns of scheduling be explored and tested.

16. That the problems associated with shift work and child care be addressed.

17. That nurses' job descriptions be redesigned to eliminate time spent by nurses on non-nursing functions and that adequate personnel for non-nursing functions be provided.

18. That the effects of casual and part-time staff on the continuity and quality of care be reviewed.

19. That funding be made available to allow agencies to implement nursing workload measurement systems according to the standards set by NANB.

20. That Boards of hospitals, nursing homes and other health care agencies re-examine the criteria used to determine the allocation of funds to nursing departments to ensure adequate resources. Budgets for nursing care must not include non-nursing expenses.

21. That primary nursing be investigated as a feasible method of nursing care delivery with cost-effective benefits for both clients and nurses.

22. That clearly delineated career paths, separate from the administrative role for nurses, be established (clinical ladder concept).

23. That improved mehcanisms for financial and professional recognition of nurses who work in the practitioner role be explored and established.

24. That funds within institutions be allocated to provide adequate support for:

    (a) establishing modes for clearly identifying the continuing nursing education needs of nurses in the work setting,

    (b) planning and implementing continuing education programs based on clearly identified learning needs, and

    (c) providing nurses with learning resources for self-directed learning activities in the workplace (e.g. modularized critical care course).

25. That the concepts of professional development days and deferred salary be incorporated into the collective agreement for nurses.

26. That adjustments in staffing assignments be facilitated to accommodate attendance at continuing education activities.

27. That funding within the advanced education system be reallocated to permit the continuing expansion of basic baccalaureate nursing programs.

28. That funding be made available for the development of Masters in Nursing programs in the province in both languages.

29. That financial resources be reallocated from capital to operating budgets within the health care system.

Introduction

The purpose of this submission is to present to the Nursing Human Resources Advisory Committee the concerns of the Nurses Association of New Brunswick (NANB) regarding the worklife of nurses in this province. According to the Nurses Act (1984), NANB is responsible for advancing and maintaining the standard of nursing in the province, and providing for the welfare of the public and the 8000 members of the profession.

One of the greatest challenges in the health field today is the effective management of health manpower resources. In the formal health care system, nursing personnel outnumber all other health workers combined, and it is essential that sufficient attention be given to the manpower planning of this group (Report to the New Brunswick Nursing Manpower Committee, 1980).

The effective management of nursing manpower resources demands considerably more than ensuring the availability, in adequate numbers, of nursing personnel. Additional and equally more important facets of manpower management are:

1. ensuring that available nursing personnel are appropriately educated and possess the skills required to provide a high quality of nursing care, and
2. ensuring that the work setting (or environment within which nursing care is given) is conducive to high quality nursing practice (Klippert, 1982).

The NANB statement of philosophy indicates the belief that nursing exists in response to the needs of society. The major force for change within the nursing profession comes from society itself. Today's nurses are seeing accelerated changes in the general population, in the systems created by society and in the technology available to society. These changes have a direct impact on nursing and nurses alike.

Nurses are experiencing conflict because changing demands are not being met with comparable changes in resources. Unmanaged conflict leads to increased differences of opinion, decreased productivity and low morale. As it polarizes groups and individuals, it encourages irresponsible behavior, blocks unified action, diverts energies from the primary task and creates suspicion and distrust. **Therefore, it is imperative that the concerns of the nursing profession be addressed to ensure that there will be sufficient numbers of well prepared, skilled nurses to provide the highly sophisticated nursing care required by our changing society.**

I. Roles and Functions of Nurses

Roles for nursing are defined by the Canadian Nurses Association (CNA, 1987) and by NANB (1988 a). The **independent** role of the nurse involves judgements about a client's need for nursing and appropriate nursing interventions based on theory and practice from the discipline of nursing. The **interdependent** role of the nurse involves judgements made in collaboration with other health care professionals. These judgements are based on nursing theory and practice as well as the practice of other disciplines such as physiotherapy, education, social work, and medicine. There is no "dependent" role of nurses, since they are legally and professionally accountable for their own actions.

As the health care industry shifts emphasis from a concept of treating illness to one of maintaining wellness, greater attention must be given to the expanded role of the nurse. Exhaustive studies have documented the use of nurses as primary health workers and the major positive impacts of the use of nurses on access, cost and quality of care (NBARN, 1984). Until governments recognize and accept the need for and potential of nurses, this manpower waste will continue unabated.

Nursing service involves caring which requires considerable intellectual acuity and cannot be dismissed as intuitive. Nurses must be able to incorporate theory into practice to make the theory useful. Caring is a multifaceted concept that manifests itself in many ways:

> Caring is not restricted to the situation in which one nurse is alone in a room with one patient. It is also an exercise of caring to manipulate a budget so as to provide enough staff to handle the patient load. It is the application of the concern for caring that makes a curriculum change to include more carefully analyzed clinical work, buttressed by selected readings, self study and validation by

> examination. It is caring to help a community or organization to mount an immunization program, or provide school lunches, or construct a rape crisis center, or promote an alcohol counseling program. And it is caring that fires nursing up to change legislation to make needed resources available not only to the people, but to nurses themselves (Diers, 1986, p. 27).

Helping and caring form the work of nursing. The importance of the nurse as a helper is based on three factors; need, quality, and cost-effectiveness. In our society, diseases related to unhealthy lifestyles are the major killers. These include heart and cerebrovascular disease, respiratory disease, and various cancers. Treating disorders of lifestyle involves behavioral alterations, not pills, nor surgery, nor costly laboratory tests. The nurse's educative supportive role is essential during periods of hospitalization as well as in the community setting. Given appropriate resources, the nurse is best able to provide cost-effective health counseling. Finite limitations to the application of medical technology are imposed in part by economic, geographical, ethical, and other considerations. The emphasis on health is both economically and rationally defensible. With an aging population there is a need for practitioners who are willing and able to spend goal-directed time with individuals assisting them to establish and move toward health goals, even while contending with one or more chronic illnesses.

Nurses, because of the scope of their education, are the practitioners prepared to provide the help needed, and to coordinate the helping team, not only in illness situations, but also to maintain wellness and to assist clients to move forward to a state of wellness from illness. That nurses in New Brunswick perceive these roles and functions as their own is confirmed by a study conducted by the NANB Special Committee on Entry to Practice (1987 a).

To summarize, nurses have both **independent and interdependent roles** in nursing practice, administration, research, and education (NANB, 1988a). Nurses are neither handmaidens nor servants. The image of the nurse as an individual who takes orders and performs tasks is inconsistent with that of the skilled practitioner whose knowledge and judgement provides 24 hour client care. Because of this round-the-clock function, the nurse assumes responsibility for assessing the needs of patients, and planning, implementing, coordinating and evaluating care. Nurses use their knowledge of the human body, human behavior, human society and the environment in which humans live, communication and learning theory when given the opportunity. A background in science is enhanced by LEARNED helping behaviors.

Personal satisfaction results when structures are in place which support professional care giving. Personal stress results when professional care giving is compromised. The worklife of nurses is New Brunswick is such that their ability to provide professional care is compromised. In the following pages, NANB will address some of the factors that are impacting negatively on the worklife of nurses in this province.

Recommendation #1

That the province of New Brunswick encourage federal and provincial manpower planning for the '80's and '90's that reflects the changing role of nursing in health care particularly in the community setting.

Recommendation #2

That great prominence be given to the nurses' role in health screening, assessment, health education and coordination of services.

Recommendation #3

That the Department of Health and Community Services be restructured to create a workplace that encourages nurses to fulfill present and future nursing responsibilities as identified by the nurses of this province.

II. Factors Impacting on the Worklife of Nurse in New Brunswick

A. The Public Perception of the Role of the Nurse

A multitude of studies have dealt with the image of nurses in relation to social class, the status of nursing as a profession and the public's perception of nursing education and their opinion about the nurse's expanded role. The findings tend to support the traditional view of nursing, emphasizing the subservient role of nurses to that of physicians, their alliance with hospitals and the technical nature of their work.

In carrying out her duties, the nurse was, and in many ways still is, expected to bring to the patient that selfless devotion of a mother, to the physician the wifely virtue of obedience and to auxiliary personnel the firm but kindly discipline of a household manager. This pattern has, with slight variations, persisted over the years--despite the high level of education many nurses have attained, despite the broad range of skills they have acquired and despite the efforts of nursing leaders to establish nursing as an autonomous profession.

The nurse as heroine, handmaiden and harlot continue to be recurrent themes in contemporary fiction and video, and none present an image of career choice for serious young men and women who want to achieve social respect and a career progression Kalisch & Kalisch, 1982; Muff, 1982). Kalisch and Kalisch (1982) contend that the portrayal of nurses in the media reveals values about nursing that operate in society at a subconscious level.

The public perception of nursing persists in spite of research that nursing intervention can cut the costs of health care and enhance wellness in at-risk groups such as postmyocardial infarct patients, hypertensive patients, chronically ill elderly, and postoperative renal transplant patients (Fagin, 1982). Numerous studies indicate the value of nurse midwives in achieving major reductions in premature births, neonatal deaths, and percentages of low birth weight babies (Fagin, 1982). Public health nurses have long conducted vision screening of pre-school of school-age children as part of their on-going health assessment. Yet even this traditional function is being challenged by the New Brunswick Association fo Optometrists which is publicly questioning the competence of public health nurses.

Nursing is rendered invisible because of health systems that emphasize the role of the nurse as an employee. Nursing is further kept powerless by legislation and powerful physician lobbies which retain the physician as the major point of entry to care and limit access to the system. The full potential of the nursing profession will not be realized until the physician-centered pattern of medical care is replaced by a "health team" approach and perhaps most importantly, until government recognizes the crucial role of nursing personnel in the health care system.

Primary health care, by stressing team work and the need to match the most qualified and readily available health personnel with essential health care, would open the door for the nursing profession to prove its worth. Yet the nursing profession is constrained in this regard due to the government's lack of action in operationalizing this concept as outlined in the Canada Health Act.

Recommendation #4

That the Province of New Brunswick support the Canada Health

Act to allow the emergence of a health insurance program that would stimulate the development of health promotion and disease prevention programs, permit the introduction of new entry points to the health care system, and promote the appropriate utilization of qualified health personnel.

B. Physicians' Perceptions

Physicians do not recognize that nursing is an autonomous profession with its own body of knowledge. By their own admission, physicians are at a loss to understand clearly what nurses are saying about their professional practice in the 80's (Gray, 1987).

In a brief presented to the Nova Scotia Royal Commission on Health Care, a physician made numerous statements that reflect this lack of understanding. This physician told the commission that it costs about 40% more to hire a nurse with a baccalaureate degree, a statement that has no factual basis in this country. Furthermore, he was quoted in the newspaper as saying, "providing basic patient care may well be more dependent on the person and not degrees; on personality, not intellect; on compassion and not technical skills or knowledge of physiology" (The Canadian Press, in the Daily Gleaner, May 18, 1987).

Nurses have identified a lack of professional recognition for their contribution to patient care, and increasingly resent physicians' attempts to deny them input into and opportunities to contribute to decision affecting patients' care (Jenny, 1982).

In a survey of physicians' perceptions of nurses, 75% of the doctors viewed nurses as their assistants, nothing more. They did not want collegial relationships with nurses (Lee, 1979). This perception is clearly incongruent with the reality of the professional practice of nursing. Nurses have a complementary role and perform functions distinctly nursing. In the same survey almost 60% of the physicians indicated that they believed that nurses had enough say in patient care, and another 10% thought that nurses have too much authority. However, as people have become better informed about their bodies, their minds, and their health they feel a need for increased participation in activities related to their own health. NANB believes that nurses have a professional responsibility to act as patient advocates in this regard (NANB, 1988a). Again, the lack of support from administrative bodies and government in recognizing the contribution of nurses has reinforced and perpetuated the outdated and incorrect perceptions of physicians.

Nurses are concerned about the quality of life for Canadians, the quality of health care and cost effective measures to achieve this. Nurses would prefer to work collaboratively with physicians in helping design the health care of the future. This can only be accomplished in an atmosphere of mutual trust and respect.

Recommendation #5

That a joint practice committee representing physicians and nurses be established in each agency to promote dialogue on professional issues.

C. Organizational Structure/Organization of Nursing Units

1. Bureaucratic Versus Professional Work Systems

Although professional nursing is continually evolving to meet the needs of a changing society, structures have remained static, and largely unresponsive to the professional nature of nursing.

In essence, the two dominant value systems of a bureaucratic work system, and a professional work system are in conflict (Johnson, 1971). The focus of the bureaucratic work system is on extensive division of labor, task oriented performance, routine functioning, and conformity to rules, regulations and policies, with an administrative hierarchy having control at the highest levels. These factors, as well as other professional (e.g. medical) hierarchical demands are characteristic of a bureaucratic structure which limit independent decision-making by nurses. Conversely, the focus of the professional work system promoted by NANB is on providing a service, based on a systematic body of knowledge, where practice judgements and actions are guided by professional standards, ethics, and accountability. For many nurses, it becomes easier to abandon nursing than to try to defend their values in an unsympathetic and unyielding work milieu.

2. Lack of Autonomy

The **lack of professional autonomy** is inconsistent with professional nursing, where nurses are members of a self-regulating body (NANB), but in fact, do not have control of their practice or functions in their work setting. Consequently, nurses experience little opportunity for decision-making and creativity in their practice, and their knowledge and skills are underutilized. In a study of hospital nurses' job satisfaction and turnover, staff nurses saw autonomy as the most important determinant of their job satisfaction, and that it had a subsequent effect on their decision to remain or to leave the hospital (Wisman, Alexander & Chase, 1981).

The traditional image of the nurse in a bureaucratic, hierarchial governance structure is reinforced as a low-level employee rather than a professional practitioner who is central to the provision of health care. Most present day organizational structures perpetuate the external control of nursing. Decision-making about nursing, and its role in the health care system is by boards, administrators, physicians, and with the integration of health and community services, by social workers. Nursing should be responsible for directing and evaluating nurses. It is precisely the issue of who has control over nursing that governments need to address and rectify.

Recommendation #6

That hospital administration, boards and physicians be provided with an orientation concerning the professional role of nursing in health care.

Recommendation #7

That the senior nursing person (however designated) be made directly accountable to the chief executive officer and that provision be made for her direct communication with the Board of Trustees of the health care agencies.

Recommendation #8

That the senior nursing person be provided with the authority as well as the responsibility to determine how costs for the nursing department will be defined, controlled, accounted and monitored.

Recommendation #9

That regional senior nurse managers be appointed, with management line authority, to oversee and evaluate nursing services in the community setting.

3. Decentralization

The bureaucratic organizational structure is outdated for the 1980's and is inconsistent with the current preparation and role of the nurse. There is general agreement that turnover is a sympton of the unwillingness of most health care power groups to share their control of both resources and decision-making, and is a critical indicator of the degree to which the traditional, authoritarian management styles continue to reign (Kernahan, 1982. The purpose of **decentralization** is to achieve better decision-making and to promote increased **accountability**. Decentralization would allow for **participative management** which would in turn promote autonomous work environment.

Participative management provides for both upward and downward communication, open communication, and promotes democratic leadership and problem solving at the unit level. Furthermore, it fosters both job satisfaction and professional development (Dieffenbach & Marvulli, 1987). Although the concept of participative management involves the staff in decision-making, in no way does it allow the manager to relinquish her decision-making responsibility. In fact, with decentralization, there is a greater need for well prepared nurse managers. Sharing information, and involvement in decision-making contributes to recognition and value of ALL nurses in the organization.

Recommendation #10

That organizational structures in hospitals, nursing homes and other health care agencies be decentralized in order to promote autonomy of professional nursing practice and reduce the levels of supervisory personnel.

Recommendation #11

That participative management be explored as a feasible method of decision-making.

Recommendation #12

That crisis funding for development and provision of management courses be available over the next five years to all senior nurse managers and administrators in health care agencies who are not currently prepared.

4. Barriers to Job Satisfaction

Many studies have been conducted on the job satisfaction of nurses and the findings are consistent. The most common areas of dissatisfaction include staffing, lack of recognition for professional contribution, lack of financial rewards, shift work, lack of autonomy, exclusion in decision-making, limited opportunities for promotion, inadequate orientation programs, and few provisions for continuing education. Job satisfaction and dissatisfaction are known to exert direct influences on recruitment and retention. Yet this awareness appears to exist only as words on paper. Regretably, little action has been taken on the multitude of recommendations for changes.

Many of these problems are well known to nurses and administrators alike, and have been dealt with in other documents of the Association. It is not the intent of NANB to provide a comprehensive review of all the factors contributing to the dissatisfaction of nurses. However, some of the current key issues will be addressed along with suggestions for appropriate action.

(a) Reality Shock

Kramer (1974) found that the discrepancy between the values and expectations that student nurses learned in school and the realities of the job produced an intense emotional reaction and flight from the profession.

Reality shock appears to occur in two forms. Many nurses report that the responsibility they were given as new graduates was overwhelming. There is virtual unanimity among nursing educators and nursing adminisrators that nursing programs do not (and are not designed to) provide the graduates with all the skills necessary to undertake all nursing functions in whatever setting they may be working with a uniformly high degree of competence (Klippert, 1982), and yet the reality of the practice setting is that all nurses are expected to perform equally. This is an unrealistic expectation, especially for the new nurse who receives little or no orientation. NANB recognizes that new graduates will require direct sueprvison in performing certain nursing skills as outlined in the Nursing Skills List (NANB, 1988b). It is the responsibility of the employing agency to ensure that the proper supervison and support is provided.

The second form of reality shock occurs once the new nurse has "settled into the routine." The same nurses who reported being overwhelmed by their responsibility as a new graduate stated that as they gained experience, the responsibility was less than they were prepared to assume. Nursing schools raise expectations among nurses that their education will be used on the job. Since many nurses feel they cannot use the skills they gained in school, they become frustrated and dissatisfied. For example: "In university I was taught to think a lot for myself. When I came out I was expected to follow orders and policies." In a recent study of job satisfaction among BN staff nurses in Canadian hospitals, nurses stated that leadership skills were not used because leadership was not part of the staff nurses' job (Cairns & Cragg, 1987).

Satisfaction is the balance between what one expects and what one receives. Nursing administrators, caught in the middle of the education/employment conflict, assert that if only educators would socialize students to the "real" world of work, as well as to the professional nurse role, there would be less reality shock and no nursing shortage (Jenny, 1982). NANB believes that socializing students to the "real world" will not necessarily prevent or alleviate the nursing shortage. In fact, the result might very well be a long-term exacerbation in the nursing shortage. Furthermore, NANB does not condone an activity that does nothing to change poor working conditions and promotes their passive acceptance by nurses.

Perhaps administration needs to be socialized to the full potential of nurses in the health care setting. However, at the same time we must develop ways of recognizing the variations in levels of competency that necessarily exist among nurses in the practice setting. Furthermore, the literature suggests that adaptation to work can be greatly facilitated by a realistic orientation program for new staff, in which time to acquire the pace and values of the employer is provided.

(b) Orientation Programs

In 1982, two documents were published in New Brunswick that indicated problems with the orientation programs for nurses in New Brunswick hospitals. A review of nursing manpower in

New Brunswick in 1982 revealed that the level of development and organization found in formal nursing programs was not evidenced in the available orientation programs (Klippert, 1982).

A study of the transition from school to work of diploma nursing graduates in 1982 revealed great variation in the length and content of orientation programs offered to nurses at that time (DPA, 192). Graduates satisfaction with orientation was found to be correlated with the length of the orientation program. Sixty-one percent of the graduates whose orientation lasted two weeks or more felt "very satisfied" with their orientation, whereas only 35% of those with less than two weeks orientation were "very satisfied." Another finding of this study demonstrates how the health care system expects new nurses to function at the same level as experienced nurses. Most nurses were found to carry a full load of patients throughout most of their orientation period.

In response to the expressed concerns of nurses regarding the need for appropriate orientation programs, NANB developed Orientation Guidelines for Nurses in Health Care Agencies (1987b) and Specialty Units (1988c). Nurses will benefit from these guidelines only if they are operationalized. To achieve this goal, the difficulties encountered in mounting and financing these programs must be addressed and overcome.

Recommendation #13

That appropriate funding be provided to establish adequate periods for orientation of all nursing staff (full, part-time, and casual) as outlined in the NANB Guidelines for Orientation.

Recommendation #14

That all agencies establish orientation programs for nurses related specifically to equipment and technology prior to work assignments.

(c) Staffing

Inadequate staffing and inflexible scheduling continue to be major sources of dissatisfaction for nurses. Shift work continues to be one of the major disadvantages of a career in nursing. The problems associated with shift work and their affect on recruitment and retention have been well described in the literature. Yet we see virtually no attempts to explore alternate patterns of scheduling. This problem must not be accepted as a fact of life simply on the basis of its chronicity. This is a perfect example of the need for participative management. The creativity required to solve this problem will be generated only when the responsibility for decision-making is shared at the grass-roots level.

Recommendation 15

That alternate, more flexible patterns of scheduling be explored and tested.

Recommendation #16

That the problems associated with shift work and child care be addressed.

The key factors that should determine staffing patterns and staffing levels include:

(a) nursing practice standards
(b) program standards and philosophy of care
(c) modes of delivery of nursing care (e.g. team, primary)
(d) education and availability of nursing staff
(e) patient satisfaction
(f) quality of care
(g) patient need

Yet, allocation of resources primarily continue to be based on number of beds and on medical diagnosis. NANB recently completed a survey of all New Brunswick hospitals regarding methods of staffing. **Only 20% of the respondents were using any kind of formal workload measurement to assist them in their staffing programs.** All but one of the respondents indicated that they believed the mathematical formulas based on occupancy rates and a fixed number of patient care hours per day that government uses in budgeting are **not** accurate representations of reality.

The nursing budget is seen as one of the institution's largest cost factors and becomes the primary target for cutbacks. **Budget imperatives often take precedence over the key factors identified as important in making nurse staffing decisions.** All too often, the focus is on budget, with **little regard for quality,** and the nursing units are stripped of appropriate numbers of nurses. The outcome of this results in questionable quality of care and in some situations, is totally unsafe. NANB is alarmed at the number of calls received from members who describe staffing situations that are intolerable and clearly jeopardize the safety of patients and nurses.

In an attempt to keep costs down in the nursing department, one simplistic remedy has been to only consider numbers of staff irrespective of their preparation, hire part-time and casual R.N.'s who are said not to "qualify for benefits, and to hire greater numbers of auxiliary staff, who only appear to cost less" (Minyard, Wall & Turner, 1986). Nurses are thus caught in a web, which creates much personal conflict and stress in being accountable to both bureaucratic and professional systems.

In recent years there has been a trend towards the use of workload measurement systems to determine staffing needs. It is inappropriate and irresponsible to continue to use figures from 1966 such as 3.5 hours of care per patient day for estimating nurse staffing. Such figures were often arrived at by individuals outside the nursing profession with limited appreciation for the complexities of nurse staffing and are obsolete. Documentation of the workload of nurses is required to ensure that resources are distributed and utilized appropriately.

In 1988, NANB established a special committee to examine the concept of workload measurement for nurses. NANB promotes the use of workload measurement, but does not believe that it is appropriate to propose the enforcement of a specific system. However, **funding must be made available to allow an organization to implement a system best suited to their needs.** NANB has developed standards for the use of workload measurement. Again our ability to attain and maintain these standards is hampered by the lack of recognition of workload measurement by governments in their budgets. Assuming that nurses, administrators and governments share the goal of matching nursing time as closely as is feasible with patient needs (which is expressed as workload), workload measurement provides a rational basis for resource determination and allocation.

Although workload measurement methods may serve as useful tools, they are not capable of handling all aspects involved in nurse staffing. It must be recognized that while workload measurement does aid in decision-making related to numbers of staff required, used alone, they provide insufficient information for final decisions of staff required.

Central to a quality assurance program is evidence that patients' requirements for nursing are being assessed and met. Workload measurement serves to define nursing staff requirements, a prerequisite to providing evidence that care requirements are met.

Diagnostic Related Groups (DRG's) should not be viewed as an appropriate method of assessing nursing workload. DRG's are based on medical requirements, and not on parameters of nursing care. DRG's have not been found to be adequate predictors of nursing care requirements. Halloran (1985) has found that nursing diagnosis provide a more accurate determinant of nursing workload (and therefore costs) than medical diagnosis alone.

Recommendation #17

That nurses' job descriptions be redesigned to eliminate time spent by nurses on non-nursing functions and that adequate personnel for non-nursing functions be provided.

Recommendation #18

That the effects of casual and part-time staff on the continuity and quality of care be reviewed.

Recommendation #19

That funding be made available to allow agencies to implement nursing workload measurement systems according to the standards set by NANB.

Recommendation #20

That Boards of hospitals, nursing homes and other health care agencies re-examine the criteria used to determine the allocation of funds to nursing departments to ensure adequate resources. Budgets for nursing care must not include non-nursing expenses.

(d) Modes of Delivery of Nursing CAre

The functional and team modes of delivery of nursing care continue to reflect outdated notions that nursing care is not complex, but consists only of a simple set of "observable tasks."

Such a simplistic perception of nursing is inconsistent with current professional practice. We are developing a new knowledge of **theory-based practice** at an unprecedented rate. Nursing is moving away from a task-oriented practice to theory-based models of care.

The **primary nursing model** is characterized by **decentralized decision-making** and has been identified as one effective approach for the delivery of nursing care. This model shows great promise for providing an environment where the role, scope, and functions of professional nurses can be fully realized. The decentralization inherent in this delivery system is essential for autonomous practice.

The advantages of this model have been identified as reinforcing nurses autonomy, accountability, and satisfaction with low staff turnover; promoting continuity and consistency of care with greater consumer satisfaction as a result of a primary nurse providing nursing care to clients from admission to discharge; and increasing the quality of care (Aydelotte, 1983; Carey, 1979; Corputz, 1977).

Primary nursing need not be abandoned in the face of the current RN shortage. The issues of professional practice and staffing patterns must be kept separate--primary nursing is not a staffing pattern, it is a relationship between the nurse and the patient.

Recommendation #21

That primary nursing be investigated as a feasible method of nursing care delivery with cost-effective benefits for both clients and nurses.

(e) Rewarding Excellence

A concensus seems to exist among articles discussing reasons for high nurse turnover that hospitals have become progressively less satisfying places to work, and that more nurses are "voting with their feet" and leaving hospital employment for other options (Jenny, 1982). All too often those options do not include nursing.

Lack of recognition for a job well done has long been recognized as a source of dissatisfaction for nurses. Two recent Canadian studies indicate that this trend has not changed (Cairns & Cragg, 1987; Jennings & Rademaker, 1987). Cairns and Cragg reported that the many statements the nurses made about the lack of recognition indicated a need for positive reinforcement. Nursing administrators were seen as remote, dictatorial, and uninterested in staff nurses.

Jennings and Rademaker (1987) found that opportunities for promotion, participation in job decisions and credit for work were three areas of greatest concern to nurses. The disparity regarding opportunities for promotion is serious in light of the concern being expressed over nursing recruitment and the emphasis on nurses obtaining a baccalaureate degree. The nurses in the Cairns and Cragg study (1987) conveyed the idea that working general duty is an essential first experience and that staff nursing provides certain skills and background that are needed for other positions. Basically, staff nursing was viewed as a necessary "rite of passage."

Usually a nurse can advance only as an administrator, not as a practitioner. Other occupations allow for growth in money, prestige, power, rights, and responsibilities, while for staff nurses there is but a single occupation that remains essentially unchanged. Many nurses move from situation to situation seeking the novelty and change in their work environment which cannot be found in the job itself (Jenny, 1982).

Clearly, the void in **lateral promotion** along a scale of **clinical competence and expertise** must be filled. All of the nurses in the Cairns and Cragg (1987) study identified patients as the greatest source of job satisfaction. The implementation of a **clinical ladder concept** would capitalize on the satisfaction that nurses receive from direct patient care while keeping the much needed experienced nurses at the bedside. That clinical competence and expertise have not been traditionally recognized underscores the point that the work of nurses is not valued within the health care system. This situation must be rectified to ensure that there will be sufficient numbers of adequately prepared nurses to provide essential health care in the future.

Recommendation #22

That clearly delineated career paths, separate from the administrative role for nurses, be established (clinical ladder concept).

Recommendation #23

That improved mechanisms for financial and professional recognition of nurses who work in the practitioner role be explored and established.

III. Educational Preparation for Professional Nursing

Nurses' concerns for high educational standards has a history which stretches back to the inception of professional nursing associations in Canada. Indeed, the birth of these associations in the early 1900's was linked to nurses' concerns over the educational standards required to practice nursing at the time. Nurses in New Brunswick continue to strive for quality nursing education which includes preservice or basic education and continuing education.

Due to time constraints, it is not possible to address the concerns of nurses in New Brunswick regarding education in this document. However, some of these issues are contained in the Report of the NANB Special Committee on Entry to Practice which is attached as an appendix (NANB, 1987a).

At the present time, the Special Committee on Continuing Education is developing a plan for a needs assessment of nurses' continuing education. In addition, this committee is dealing with issues such as funding and resources for post-RN programs and the need for nurses with masters degrees in nursing, especially in clinical areas. This group has been instrumental in lobbying for post-basic courses in critical care and in mental health. The need for such programs is great and efforts must continue to ensure their availability and accessibility.

NANB adamantly maintains that nursing is a learned art and a science, and not an intuitive behavior. The impact of nursing education on those in the practice setting demands that the educational issues for nurses be addressed and acted upon. Nurses working in small hospitals and remote settings feel disadvantaged as a result of limited access to educational resources. Means must be found to make upgrading and continuing education available wherever nurses work in New Brunswick.

Recommendation #24

That funds within institutions be reallocated to provide adequate support for:

(a) establishing models for clearly identifying the continuing nursing education needs of nurses in the work setting,

(b) planning and implementing continuing education programs based on clearly identified learning needs, and

(c) providing nurses with learning resources for self-directed learning activities in the workplace (e.g. modularized critical care course.)

Recomemndation #25

That the concepts of professional development days and deferred salary be incorporated into the collective agreement for nurses.

Recommendation #26

That adjustments in staffing assignments be facilitated to accommodate attendance at continuing education activities.

Recommendation #27

That funding within the advanced education system be allocated to permit the continuing expansion of basic baccalaureate nursing programs.

Recommendation #28

That funding be made available for the development of Masters in Nursing programs in the province in both languages.

IV. Recruitment and Retention

The recent attention to recruitment and retention is perhaps the most obvious indicator of the nursing shortage. In fact, it is this intermittent attention that in part, created the shortage. The issues surrounding nursing today are so complex that no "quick fix" or simple solution is likely to be successful.

Many reports suggest that hospitals and governments have failed to address the real problem; that concern and money has been concentrated on relieving the symptoms by three traditional approaches:

(a) over working existing staff,

(b) supplementing staff with casual workers, and

(c) launching massive and competitive recruitment campaigns.

As long as staff attrition could be offset by a fresh supply of nurses coming through the door, traditional responses centered on recruitment were sufficient. However, nursing manpower, like other natural resources, is being perceived as a dwindling resource in the ecology of health care delivery, thus necessitating a shift of strategies from recruitment to the retention of the existing workforce. **Incentives which encourage career longevity, job stability and decreased manpower turnover must be developed.** While recruitment is necessary, dependency on it, without additional actions elsewhere is only an avoidance of the real problem.

Recruitment of a continuing supply of nurses from suitably qualified candidates will depend in part on grappling with the status or "image" problems plaguing the nursing profession. To meet the challenges of the future scope of nursing practice, nursing needs not just live bodies, but individuals with the characteristics and potential that other professions are seeking. To be competitive in the career market, nursing has to offer a future as attractive as other vocations, while at the same time meeting the public's need for nursing care. A massive public relations campaign would seem in order, but this cannot be credible unless expressed deficiencies in the worklife of the nurse are corrected. As Fagin (1982) says, **"Ambiguity and exaggeration**

cannot be converted into a successfully persuasive campaign."

V. Long Range Planning and Health Care Dollars

There is an urgent need for long range planning in health care to encompass both the assessment of peoples' needs in New Brunswick and to examine cost-effective approaches to the delivery of health care.

NANB believes that legislators must consider the reallocation of health care dollars from capital expenditures to operations. Nurses are strongly opposed to the perpetuation of outdated systems of health care delivery.

Recommendation #29

That financial resources be reallocated from capital to operating budgets within the health care system.

Recommendation #30

That health care dollars be allocated to increase community based services in New Brunswick.

Recommendation #31

That a Principal Nursing Officer be appointed for New Brunswick, similar to the federal position.

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